

The Rhode Island Global Consumer Choice Compact Waiver



*Person-Centered, Opportunity Driven, Outcome-based, System
of Coordinated Health Care*

Application for the Rhode Island Consumer Choice Global Compact Waiver

The Rhode Island Consumer Choice Compact Waiver

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EXECUTIVE SUMMARY

A. STATEMENT OF PURPOSE: The Principles of Medicaid Reform

Over the years, the Rhode Island Medicaid program has been subjected to a host of incremental changes that have fragmented the organization, financing and delivery of Medicaid services. The system is now difficult for consumers to navigate and understand. The Rhode Island Global Compact Waiver reform proposal seeks the flexibility to create a stronger and more streamlined system to identify consumers' needs and build service capacity in the community to meet those needs in the right place and at the right time. In addition to improving the efficiency and efficacy of services for consumers, the Global Compact Waiver would improve the efficiency of administering the Medicaid program through smart purchasing techniques and performance-based contracting that works with community providers to implement evidence-based and cost-effective services. The flexibility under the Global Compact Waiver will provide the Rhode Island Medicaid program with a greater range of options in managing the costs and delivery of services to consumers in order to assure the sustainability of the program in years to come.

The Rhode Island Medicaid Reform Act of 2008 (R.I.G.L. §42-12.4) directs the State agencies responsible for administering Medicaid -- the Rhode Island Executive Office of Health and Human Services (EOHHS) and Department of Human Service (DHS) -- to apply for a global waiver under the authority of Section 1115a of Title XIX to restructure the State's program to establish a "sustainable cost-effective, person-centered and opportunity driven program utilizing competitive and value-based purchasing to maximize available service options" and "a results-oriented system of coordinated care."

From the administrative and financing perspective, the proposal presented here establishes a new State-federal compact that provides the State with substantially greater flexibility than is available under existing program guidelines in exchange for federal funding certainty. Rhode Island will use the additional flexibility afforded by the waiver to redesign the State's Medicaid program to provide cost-effective services that better meet the changing needs of beneficiaries. In exchange for the increased flexibility and the opportunity to invest in Medicaid reform, the State assumes a degree of financial risk with respect to caseload and inflation trends.

Under the proposed compact, Rhode Island will operate its entire Medicaid program under a single waiver demonstration except for disproportionate share to hospital (DSH), payments to local educational agencies (LEAs) and administrative costs. All Medicaid funded services on the continuum of care -- from preventative care in the home and community, from acute care in high-intensity hospital settings to long-term and end-of life-care -- will be organized, financed and delivered through the proposed demonstration. Therefore, Rhode Island is requesting that the Centers for Medicare and Medicaid (CMS) grant the State the authority to implement the Global Compact as a Section 1115 (a) demonstration project. Accordingly, Rhode Island's Section 1115 RIte Care and RIte Share programs for children and families, the 1915(b) Dental Waiver,

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State Plan services and its various Section 1915 (c) Home and Community Based Services waivers will become a part of the Global Consumer Choice Compact Demonstration.

1. Guiding Principles of Reform

The design of the Global Compact waiver was guided by Medicaid reform principles, each of which has either been influenced by or integrated into the demonstration. This core set of principles is as follows.

- ❖ **Consumer Empowerment and Choice.** If consumers have more information about and control over their health care and community support options, they will make more reasoned and cost-effective choices about their health, often enhanced when their good decision-making is rewarded.
- ❖ **Personal Responsibility.** Consumers will become better health care purchasers for themselves and their families when they have easy to understand and accurate information and timely access to a continuum of needed services. Health Savings Accounts and the wraparound planning process are two methods that demonstrate the effectiveness of consumer choice and personal responsibility.
- ❖ **Community-based care solutions.** Rhode Island is committed to offering consumers care in the “least restrictive settings” and to assisting more beneficiaries who require long-term care to remain in the community. The State’s Medicaid redesign is based on the assumptions, articulated most clearly in the Olmstead law case and the New Freedom Initiative, that an expanded continuum of care that includes community-based services will result in improved health, quality of life and more cost-effective care.
- ❖ **Prevention, Wellness and Independence.** The Medicaid program will strive to better enable consumers to receive individualized health care that is outcomes-oriented and focused on prevention, recovery and retaining/maintaining independence.
- ❖ **Competition.** Competition among health care providers is necessary to ensure best value purchasing, leverage resources and create opportunities for improving service quality and performance.
- ❖ **Pay for Performance.** Medicaid purchasing and payment methods will encourage and reward service quality and cost-effectiveness by tying reimbursements to physicians, dentists, hospitals, and other major health care providers to common, evidence-based quality performance measures, including patient satisfaction.
- ❖ **Improved Technology.** Current technology must be leveraged to take advantage of recent innovations and advances that assist decision makers, consumers and providers to make informed and cost-effective decisions regarding health care. Timely feedback to consumers on the quality and outcome of the services helps them to be directly involved

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in the service delivery to adjust to their individualized needs, often resulting in reduced cost of the episode of care.

Translating the principles of reform into daily operations requires that the State fundamentally restructure the way RI Medicaid services and programs are organized, financed, and delivered. The challenge for the State is to change both prevailing conceptions and expectations about the Medicaid program as well the way it is structured.

2. The Concept for Change

The “Global Compact” the State introduces here has two dimensions: (1) a fixed allotment or capped pool of federal dollars to spend during the demonstration; and (2) the administrative flexibility the State requires to manage costs within this capped allotment. Built into each of these dimensions are assurances and protections -- both programmatic and financial -- for both the federal government and the State.

It is important to underscore that the terms of the Global Compact proposed here are unique to Rhode Island and without precedent across the states. However, the financial premise underlying global budgeting has been applied to health care systems worldwide. Today, global budgeting is used at the federal level by the Veteran’s Administration and by state governments to set spending limits while providing managerial flexibility to selected hospitals, school districts and the like.

Despite the concept’s familiarity, the idea of using global budgeting to reform Medicaid first surfaced in earnest relatively recently, midway through the first term of the President George W. Bush’s Administration. It was also at about this time that many states, like Rhode Island, began to recognize that Medicaid expenditures were rising at a higher rate than general revenues and/or consuming a greater proportion of their annual budgets than any other single program. Since then, several states have adopted a global budgeting approach for certain Medicaid services (e.g., hospitals, long-term care services) and populations (e.g., adults with disabilities). Rhode Island is the first state to request the demonstration authority under Section 1115(a) of Title XIX to use global budgeting as a financing mechanism for all Medicaid populations and services.

Rhode Island’s fiscal crisis certainly was a key factor driving the State’s decision to develop a global budgeting approach for the Medicaid program. The fixed allotment of federal dollars the State will receive if the Global Compact waiver proposed here is approved provides a measure of fiscal predictability to both the federal government and Rhode Island that would otherwise be lacking during what is expected to continue to be a period of significant uncertainty. However, the decisive factor for the State is the second dimension of the Global Compact -- the administrative freedom to manage Medicaid costs within the federal fixed allotment. It is this flexibility that will afford the State the opportunity to comprehensively reform RI Medicaid, to both preserve and build on the gains that have already been achieved and to pursue changes in the organization, finance and delivery of services that will make the program more cost-effective

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and sustainable for years to come. This flexibility will also provide the State the ability to develop person-centered programs and to offer its beneficiaries options and choice.

The State is confident that the Global Compact is a responsible and appropriate policy for the Medicaid program for several reasons. First, under the Global Compact, the State will have the freedom and flexibility to organize and deliver services across populations and acute and long-term care settings that address the complex and inter-related needs of beneficiaries throughout the life-cycle. Second, the State will have the latitude to leverage its purchasing power to create new provider markets or drive change in existing ones as the service needs and preferences of beneficiaries change. And third, there is a growing consensus nationwide that, in an era of limited resources, everyone including Medicaid beneficiaries must become more responsible health care consumers. Under the Global Compact, the State will be able to implement strategies that have been used successfully in the commercial health insurance market that encourage and reward beneficiaries who take responsibility for their own health and wellness.

The State recognizes that the Global Compact – as both a financing and policy strategy – is not without limits. For example, the State will be required to exercise a far greater level of fiscal discipline than is typical for an entitlement program. During public forums about the proposed demonstration, questions surfaced about how beneficiaries would be affected if the State budget allocation for Medicaid was further reduced. The State is committed to using the flexibility provided under the waiver to ensure that access to services and plans of care will be determined on the basis of medical necessity, and health and welfare, not by the dictates of the budget. Moreover, protections built into the Global Compact are designed to not only preserve the safety net established under Title XIX, but expand it and make it more durable in the event of unforeseen fiscal pressures and/or calamities.

B. MERGING PRINCIPLES AND PRACTICE: The Right Services, at the Right Time, and in the Right Setting

Although Rhode Island Medicaid has received national acclaim for access and quality across populations, the program is prone to inefficiencies, most of which are related to type of service and care setting. For example, Medicaid enrollees are utilizing far too often emergency departments (EDs) for primary care services; adults with disabilities, especially those with serious behavioral health conditions, are particularly overly reliant on EDs for their care. High cost institutional and residential settings provide a disproportionate share of Medicaid funded long-term care for frail elders, adults with developmental disabilities and catastrophic illnesses and children with serious emotional disturbances.

Each of the State agencies responsible for administering Medicaid funded services to these populations has endeavored to decrease reliance on costly service venues. For the most part, these piecemeal efforts have only succeeded at the margins. As a result, a significant percentage of Medicaid expenditures continue to be spent serving beneficiaries in these high cost settings. Moreover, despite the best efforts of the health and human services agencies, the contractual incentives for and number of pathways to community-based care remain inadequate. To re-orient the Medicaid program to incorporate the principles of reform and shift the bias away from high

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cost and institutionally-based forms of care, the State's health and human services agencies have collaborated to develop a broader view – a view that focuses on the “person” and the full continuum of care options that can and should be available to the beneficiary across the lifecycle.

The State's Medicaid reform proposal seeks to rebalance the long-term care system away from high cost institutional venues and toward home and community based settings such as shared living arrangements, assisted living and at-home care. Thus, translating principles into practice on the long-term care side requires the centralization of certain programmatic functions (i.e., long-term care intake, assessment and referral), the reconfiguration of others (i.e., combining home and community-based waivers), and the integration of still others (i.e., braiding long-term care funding streams). Under the Global Compact, decisions about the type of service and setting will be determined in conjunction with the beneficiary and his or her family and will be based on an assessment of level of care needs and personal preferences instead of population or funding stream.

To further promote the principles underlying the Medicaid Reform Act, existing support systems that foster self-determination and independence will be drawn upon and strengthened wherever possible. Personal choice is critical and an important factor that will affect the success of this effort. Accordingly, every individual and/or family (or guardian if available) must understand the full range of support options open to them before deciding which is best for their unique situation. This applies across the lifecycle and care continuum and to beneficiaries served through a managed care plan or fee-for-service, in the community or an institution, and via a voucher, health savings account, or other self-directed care option.

To make such choices meaningful, the State must expand the range of community- based service alternatives beyond existing support and full service levels to the full extent feasible. Built into the implementation of the redesigned system is a centralized Assessment and Care Coordination Organization (ACO) for beneficiaries seeking or at risk for long-term care services. One of the chief responsibilities of the ACO is to continuously educate the public about various service options and to ensure that those seeking alternative service options and supports make informed decisions about their own health care.

The flexibility of the Global Waiver will allow the State to enroll all populations without other third party coverage into a managed care plan or primary care case management practice. Care management is a pivotal element of the Medicaid reform initiative, as it will provide the first line of defense against the over-reliance on high cost services and serve as the principal source of the health services necessary to maintain, attain, or optimize the health and wellness of beneficiaries. Mandatory enrollment in a care management system for each beneficiary's medical care will serve as the nexus for coordinating and/or integrating services across the health care continuum as an individual's needs change over time.

On the acute care side, the State must ensure both in principle and in practice that beneficiaries take greater responsibility for their own health care by contributing to the costs of coverage to the full extent their income allows and paying a premium for services provided in high cost (i.e. ED) rather than appropriate (i.e., primary care provider's office) settings. Certain beneficiaries

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will also be required to “take charge” of their health through incentives plans that reward wellness, prevention and health conscious lifestyle choices. Moreover, all parties involved in the acute care health service delivery system – providers, third-party payers, and Medicaid – will be required along with beneficiaries to pay their “fair share” of the costs for coverage.

Ensuring that every beneficiary has access to the right services in the right settings requires that the State change the way services are purchased. Not only must every Medicaid dollar the State spends achieve the best health outcome, but any dollars saved from implementing a fair share approach must be reinvested in the program to further the principles of reform. Additionally, the model of “smart” payments and purchasing must be expanded so that increased competition can yield not only the best price, but also improved capacity and performance. Toward this end, the State is committed to restructuring how it purchases and pays for services, both for acute care and on the long-term care side. This will result in new and better markets that address beneficiary needs, assure greater service quality, and provide a higher level of cost transparency.

On-going initiatives that complement the Global Compact will also be incorporated into the demonstration. For example, the State’s Medicaid Transformation and CHOICES MMIS Module initiatives along with a statewide health information exchange under construction will provide strategic resources that will assist in implementation of the demonstration. The State’s Real Choices grant and the Rhode Island Perry-Sullivan Act ¹ of 2006 -- both of which are targeted at long-term care system reform and have generated a long-term care strategic plan for Rhode Island – will guide consumer and provider outreach and efforts to change existing service markets and build new ones. (See Appendix I for a full list of these initiatives.)

C. EVALUATING THE DEMONSTRATION

As an 1115 (a) Research and Demonstration waiver, the Global Compact will incorporate a structured, ongoing and final evaluation that will be focused on answering four basic questions:

1. To what degree did the demonstration achieve its purposes, including goals, objectives and measurable, quantified performance targets?
 - Specific goals, objectives, and performance measures will track closely to the Global Compact Waiver’s three main areas of focus: Re-balancing the long-term care system, care management, and fair share (smart purchasing).
2. Did the demonstration result in changes in health status and health outcomes for enrollees? Did the demonstration result in other outcomes for enrollees, providers and for the state?
3. Did the demonstration result in greater value for the state’s expenditures?

¹ The Perry/Sullivan Long-Term Care Service and Finance Reform Act (Chapter 40-8.9-Sections 1-6),

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4. What lessons were learned as a result of the demonstration?
 - a. These lessons will result from the ongoing or “formative” evaluation, which will measure the program’s progress in achieving measurable objectives, and which will provide Rhode Island policy makers and stakeholders with a valuable early warning system -- information that can be used for decision-making regarding midcourse corrections. Lessons learned will also be derived from the final, in depth waiver evaluation report at the end of the demonstration period, which will be of value to Rhode Island, as well as to other states who may consider implementing components of Rhode Island’s demonstration.

The evaluation will be focused on measuring the degree to which the goals and objectives of the demonstration, detailed in Chapter Two, have been achieved.

D. SUMMARY

Rhode Islanders need to be sure that the Medicaid Program provides the right services, at the right time in the right setting. In order to design and implement a Medicaid Program that support these tenets as well as the principles of consumer empowerment, personal responsibility, independence and person-centered solutions and options; Rhode Island is submitting this Consumer Choice Global Compact Waiver.

This Waiver comprises a number of innovations that will re-balance the long-term care system, provide quality care management, and the smart purchasing of services. Under this waiver Rhode Island seeks an aggregated allotment from the Federal government in exchange for the flexibility to design delivery systems and services that are focus on our beneficiaries and across the lifespan.

Rhode Island is looking forward to working with the Center for Medicare and Medicaid Services and Rhode Island’s beneficiaries, advocates, families and providers to ensure that the Rhode Island Medicaid Program is sustainable, provides quality services, well managed and person-centered. It is critical to note that although the most significant changes proposed for the Rhode Island Medicaid program are on the long-term care side, the demonstration will provide all the populations the State covers with the incentives and opportunity to take greater responsibility for their health care choices. More importantly, the person-centered approach to service design and delivery will extend to every beneficiary; irrespective of age, care needs, or basis of eligibility. Every State agency that collaborated on the design of the demonstration is committed to ensuring no less.

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Chapter One: The Context For Change

A. THE IMPETUS FOR REFORM

Like the programs in many other states, as Rhode Island Medicaid has evolved over the years, it has expanded beyond the traditional role of a safety net to become the principal source of health coverage and services for nearly two hundred thousand Rhode Islanders. Along the way, Medicaid has taken on a variety of roles that have transformed the program from a payer and purchaser of services into an integral component of the State's health care system, the chief financier of the long-term care industry and, as such, a dominant force in the health care services environment.

In spite, or perhaps because of the program's development, the State's efforts to further the principles of Medicaid reform outlined earlier have yet to realize their full promise. Indeed, several exhaustive reviews² of the Rhode Island Medicaid program conducted over the last year found the following:

- The Medicaid system is provider-driven and not person-centered;
- Medicaid beneficiaries have limited choices over the services they receive;
- There is a pervasive institutional bias in the long-term care side of service delivery;
- Long-term care services can be provided in community-based settings often at a lower cost, and with an improved quality of life;
- Too many children are receiving services in high cost residential/group home settings rather than in their homes or less restrictive settings in the community;
- The Medicaid program does not encourage and reward prevention, wellness and disease management;
- In many program areas, payments and reimbursement methodologies are not linked to quality and performance;
- The information beneficiaries need to make reasoned choices about their health care is not readily accessible or transparent;
- The range of service setting choices open to adults with chronic illnesses and disabling conditions has been both dictated and limited by providers;
- Services for individuals with behavioral health care needs are fragmented and frequently do not treat the person as a whole nor involve family members in treatment planning/service provision;
- Some individuals and families could benefit from assistance in making decisions about the most appropriate array of services to assure there are adequate supports;
- There is no meaningful competition among providers;
- Rhode Island has one of the highest rates of elders in nursing facilities in the nation; and
- Personal responsibility is lacking for a number of important health-related decisions.

² See finding of the RI Executive Office of Health and Human Services. The Future of Medicaid, October 2007 available at: ohhs.ri.gov.

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The State's ability to address these issues has been limited by a variety of factors, including fiscal cross-pressures, program requirements and service demand, and biases built into the system. As is explained below, overcoming the challenges presented by these factors is one of the central purposes of the Global Waiver Compact.

1. Fiscal Trends and Cross-pressures

At issue for the State on the financing side of Medicaid is the growing gap between general revenues and Medicaid operating expenditures. The gap first surfaced in State Fiscal Year (SFY) 2000 as a result of fluctuations in the economy and federal financial support and the escalation in health costs. Since then, the State has initiated a variety of measures to curb Medicaid enrollment growth, contain program cost, and improve the efficiency of services. These efforts have largely succeeded in slowing the rate of growth in Medicaid enrollment and cost.

Despite these gains, the budget gap persists. With the State now in the throes of another economic recession, revenues have fallen off sharply and the fiscal prognosis for SFY 2009 is much worse than expected – the projected deficit for the year, at this point, is upwards of \$400 million and growing. These budget projections are particularly troublesome now that the Medicaid program constitutes such a large share of the State's annual budget.

As indicated in Figure 1.1, Medicaid expenditure forecasts prepared for the State show that even a quick economic recovery will not reverse current trends: by 2011, total Medicaid expenditures including administrative costs, medical claims and disproportionate share payments will comprise about thirty percent (30%) of the State's annual budget. What this means from a financing perspective is that without significant changes in the program, overall Medicaid costs may consume as much as fifty cents or more of every general revenue dollar by 2011.

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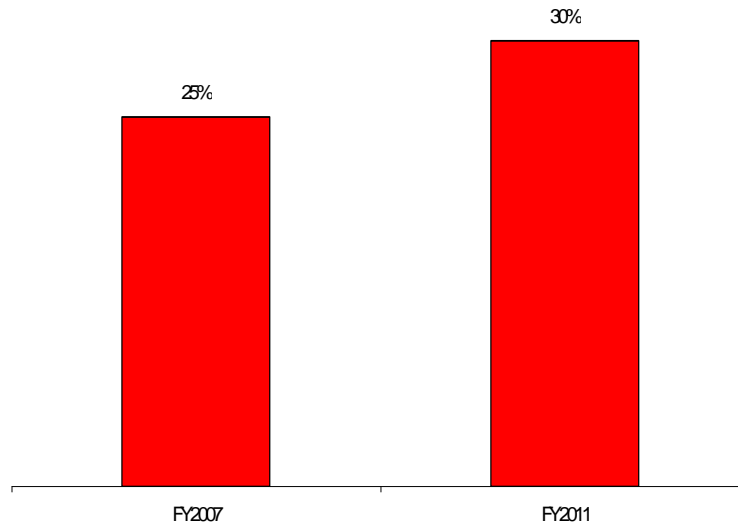


Figure 1.1: Medicaid as a Percent of State Budget

Although Medicaid has certainly benefited Rhode Islanders, the program's high cost limits the resources available to address other pressing needs, spur economic growth, and/or prepare for an uncertain future. If demographic forecasts for the State are correct, the range of choices open to the State will narrow as the majority of the baby boomers enter old age, program costs surge higher, and the gap between the rise in Medicaid expenditures and general revenues grows wider.

Sharing responsibility with the federal government for financing Medicaid has affected, and will continue to affect, the state's ability to balance program costs, revenues and other policy priorities. As federal Medicaid dollars are the single largest source of grant support to Rhode Island, the consequences of changes in federal funding for the State cannot be overstated.

For example, reductions in Federal Matching Assistance Percentage (FMAP) between SFY 2004 and 2007 decreased federal contributions to the Rhode Island Medicaid program by \$92.5 million. The major Medicaid cost containment initiatives implemented by the State over this same period offset about \$62.5 million of that amount, with general revenues covering the remaining \$30 million or so.

Compounding these fiscal pressures have been recent changes in federal guidelines that either interpret more narrowly the scope of benefits and services for which federal financial participation (FFP) is allowed or limit the ability of the states to manage the costs for care provided to beneficiaries that are dually Medicare and Medicaid eligible.

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Uncertainty about the State's capacity to handle the fluctuations in the economy as well as continued changes in federal financial assistance and guidelines underscore the need for comprehensive Medicaid reform. Yet, the State's ability to take affirmative action in that direction has been impeded by the program's scope and cost, both of which have made it a prime target for budget cuts. Indeed, since 2000, changes in the Medicaid program have largely taken the form of cost-cutting measures that, though in line with some of the principles of reform, are designed primarily to reduce the deficit in the State's budget. By contrast, the Global Compact Waiver proposed here offers the State the opportunity to implement a broad-based strategic reform plan that anticipates rather than reacts to such cross-pressures, while at the same time providing person-centered services and giving beneficiaries and their families' choices.

2. Service Demand

In SFY 2007, the State's Medicaid program provided health coverage and services to about 227,000 Rhode Islanders at some point in time. The program encompasses a diverse array of beneficiaries, who qualify for services on the basis of age, income and/or disability under one of the mandatory or optional coverage groups in Title XIX, or as SCHIP eligible children or parents under Title XXI.

The demand for Rhode Island Medicaid services differs by coverage group depending on case mix. A breakdown of the mandatory and optional groups covered under the Rhode Island Medicaid program is as follows:

Mandatory Coverage Groups -- Must be covered by all state Medicaid programs:

- ❖ Recipients of Supplemental Security Income (SSI) or Supplemental Security Disability Insurance (SSDI);
- ❖ Low-income Medicare beneficiaries;
- ❖ Individuals who would qualify for Aid to Families with Dependent Children Program (AFDC) today under the State's 1996 AFDC eligibility requirements;
- ❖ Children under age six and pregnant women with family income at or below 133 percent of federal poverty guidelines;
- ❖ Children born after September 30, 1983, who are at least age five and live in families with income up to the federal poverty level;
- ❖ Infants born to Medicaid-enrolled pregnant women; and
- ❖ Children who receive adoption assistance or who live in foster care, under the federally sponsored Title IV-E program.

Optional Coverage Groups – The State has chosen to cover these additional groups of individuals and families:

- ❖ Low-income elderly adults or adults with disabilities;
- ❖ Individuals eligible for Home and Community Based Services Waiver programs;

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- ❖ Children and pregnant women up to 250 percent and parents up to 185 percent of the federal poverty level, including children funded through SCHIP (as of October 1, 2008 only parents up to 175% of the FPL will be eligible);
- ❖ Individuals determined to be “medically needy” due to low income and resources or to large medical expenses;
- ❖ Youths up to age 21 who were in State sponsored substitute care on their 18th birthdays;
- ❖ Children under 19 with a disabling condition severe enough to require institutional care, but who live at home (the “Katie Beckett” provision); and
- ❖ Women eligible for the Breast and Cervical Cancer Treatment Program.

For the sake of simplicity, these coverage groups are organized into four Medicaid “populations” that share key eligibility characteristics: children and families, children with special health care needs, adults with disabilities, and elders.

The State offers a wide range of mandatory and optional services to the four Medicaid populations it serves. Figure 2 shows the breakdown of the mandatory and optional services available to beneficiaries. Although optional services are provided at the discretion of the State, the term can be somewhat misleading. Not only does it cover services that are essential in any health plan (e.g., prescribed drugs), under existing federal guidelines, once a state elects to provide an optional service it must be made available to beneficiaries in all covered populations.

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Figure 1.2: RI Medicaid Mandatory and Optional Services

Federal Mandatory Services	Optional Services
<ul style="list-style-type: none"> • Inpatient hospital services • Outpatient hospital services • Rural health clinic services • Federally qualified health center services • Laboratory and x-ray services • Nursing facility services for individuals 21 and older • Early & periodic screening, diagnostic and treatment services (EPSDT) for individuals under age 21 • Family Planning services • Physicians' services • Home health services for any individual entitled to nursing facility care • Nurse-midwife services to the extent permitted by State law • Services of certified nurse practitioners and certified family nurse practitioners to the extent they are authorized to practice under State law 	<ul style="list-style-type: none"> • Podiatrists' services • Optometrists services • Dental services & Dentures • Prescribed drugs • Home & Community Based Services • Prosthetic devices • Eyeglasses • Diagnostic services • Preventive services • Rehabilitative services • Services in an IMD for individuals age 65 and over • Inpatient psychiatric services for individuals under age 21 • NF for individuals < age 21 • Personal care services • Transportation services • Case management services • Hospice services • TB services for certain TB infected individuals • PACE

As a practical matter, this means that the State cannot readily adapt services to meet the variable needs of covered populations, to more aggressively manage care, or to promote more cost-effective and responsible utilization and health care choices. Given the fiscal cross pressures confronting Rhode Island, this lack of flexibility has been particularly problematic, especially for policymakers who would prefer to adopt reform driven savings rather than eligibility roll-backs.

For example, the majority of Medicaid beneficiaries are the children and families enrolled in RItE Care, the State's Section 1115 managed care demonstration, implemented in 1994. Until this year, the State was able to achieve cost savings without implementing eligibility roll-backs.

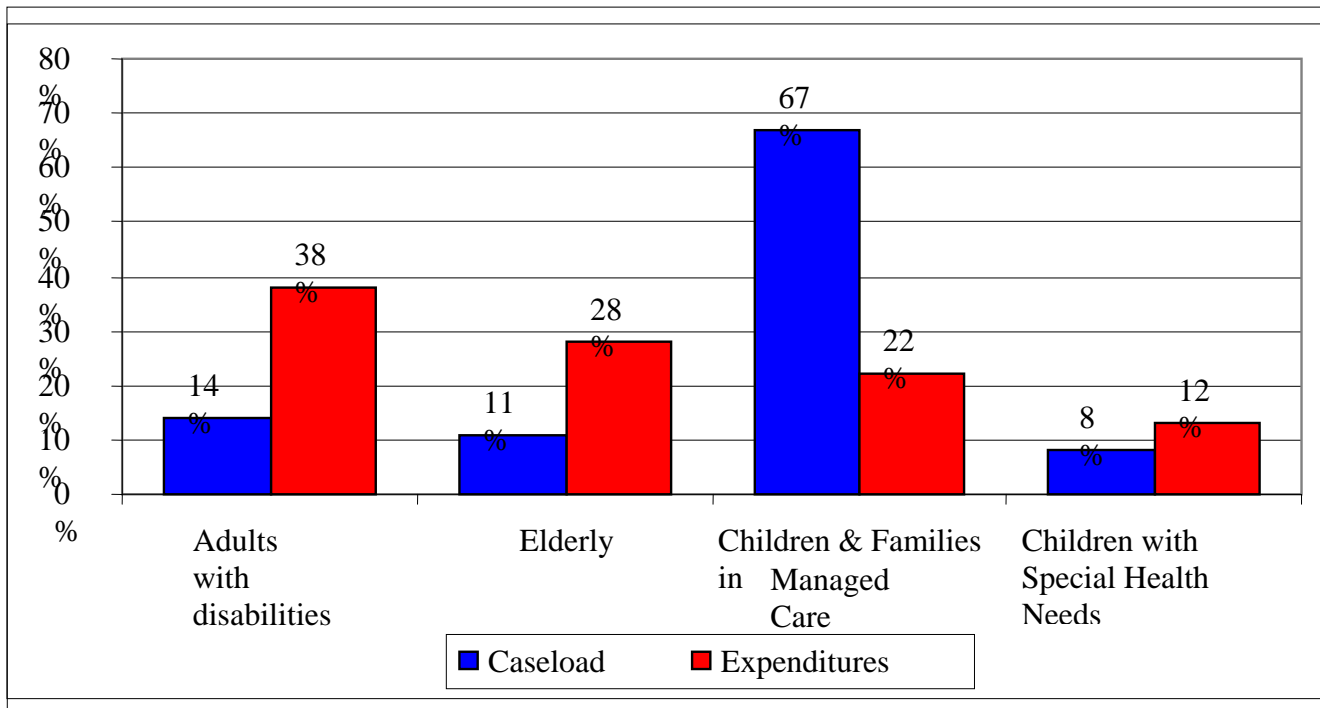
Though their health needs vary, the RItE Care population chiefly utilizes less intensive forms of care – i.e., preventative, primary, and acute care services – if not always in the most economical setting – e.g., emergency rooms v. primary care physician offices. Since SFY 2000, the State used the flexibility under the RItE Care waiver to implement RItE Share, a premium assistance program and several other reforms including cost-sharing, designed to promote personal

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responsibility and reserve RItE Care for the neediest. Today, RItE Care population is the least expensive for the State to cover on a per capita basis. (See Figure 5) In spite of this cost-effectiveness, the program's size and overall cost have often made it a target for budget cuts.

Under the Section 1115(a) waiver demonstration proposed here, RItE Care will be subsumed as part of the Global Compact rather than remain a separate demonstration. The goal in taking this step is to expand the reforms that have already been successfully implemented in RItE Care to other Medicaid populations, to introduce initiatives like health savings accounts that will take them further, and to reward providing and utilizing the right services, at the right time, in the right setting. The Global Compact Waiver will also give the State the flexibility to take a broader array of measures to avert additional eligibility roll-backs for optional coverage groups such as redesigning benefit packages along the lines of commercial plans, implementing wellness initiatives, and ensuring that all payers contribute their fair share.

Figure 1.3: Medicaid Expenditures by Population—SFY 2007



For the children requiring special health care, elders, and adults who have serious chronic and/or disabling conditions or who have experienced a financially catastrophic illness, the challenges confronting the State are more complex. In many instances, Medicaid is the only source of coverage for those that need medical services and supports for daily living to optimize and maintain their health -- e.g., personal care assistance, supervision, etc. By virtue of the fact that age and/or infirmity are conditions of eligibility for members of these populations, the demand for services and the costs of care on a per capita basis are much higher than for children and families enrolled in RItE Care managed care.

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In recent years, Rhode Island Medicaid has instituted an array of reforms that have improved the service options available to beneficiaries with chronic and/or disabling conditions. For the most part, they are population or program specific, however. This applies to beneficiaries covered under the State Plan as well the various Section 1915 (c) waivers outlined in the next section. Indeed, both the small size of Rhode Island and of the populations affected make it difficult for State to integrate and/or target services to meet the changing needs of beneficiaries across the life-cycle and comply with Title XIX requirements – waiver and non-waiver -- related to scope, freedom of choice, comparability and state wideness. The State's ability to leverage its purchasing power to drive innovations in service design, delivery and settings is similarly limited.

The State is currently the “beta” test site for a variety of health related initiatives (e.g., statewide e-prescribing and health information exchange) that complement the goals of the Global Compact Waiver. Thus, for demonstration purposes, the State's small size is an asset and an opportunity for innovative and comprehensive reform rather than an obstacle to overcome. As such, Rhode Island is uniquely positioned to provide its sister states with a model for re-inventing the Medicaid program.

3. Institutional Bias

Since the program's inception in the mid 1960s, federal Medicaid guidelines have always had what is referred to as an “institutional-bias” – that is, both eligibility for and access to covered services are more readily available to individuals receiving services in nursing facilities, hospitals and other institutional settings. In Rhode Island, as in most other states where the Medicaid penetration rate is high, the program's institutional bias has shaped the health care services market (i.e., access and availability) and utilization trends far more than the preferences of consumers or the U.S. Courts (i.e., the Olmstead decision).

As noted above, the State has taken advantage of the opportunities under federal law to use both alternative methods for determining income eligibility and Section 1915 (c) home and community based waivers to allow beneficiaries to obtain coverage while living in less restrictive residential settings and to take greater control over their care. Figure 1.4 shows a sampling of the waivers the State uses to provide Medicaid to individuals who otherwise might only qualify by giving up their independence.

Figure 1.4 Selected Section 1915 Waiver Populations

Waiver	Target Population
Aged & Disabled	Those 18 and over who are aged or have a disability that results in the need for help with ADLs and IADLs
Elders	Those 65 and older who need help with ADLs and IADLs
Developmental Disability	People of any age who meet Developmental Disability criteria: substantial functional limitation in major life areas caused by permanent mental and/or physical impairment that begins before

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Waiver	Target Population
	age 22
Habilitative	Those 18 and older who have severe physical and/or cognitive disabilities resulting in the need for ongoing skilled services or 24 hour supports
Assisted Living	Those 18 and older who require assistance with ADLs and IADLs
Consumer –Directed Personal Choice	Those 18 and older who require assistance with ADLs and IADLs and who are able to manage their own services or have a representative to manage services on their behalf
Respite for Children - ICFMR	Children who are developmentally disabled
Respite for Children - NF LOC	Children who have physical health needs
Respite for Children – Psych Hospital	Children with behavioral health needs

Additionally, the State has pursued a variety of initiatives across populations designed to: (1) reduce the reliance on institutionally-based long-term care (e.g., Real Choices Systems Transformation grants that funded a nursing home diversion program and development and implementation of a strategic plan to rebalance the system); (2) divert or transition beneficiaries from high cost institutional and residential settings into less restrictive settings (e.g., department programs developing the shared living option for individuals with developmental disabilities, alternatives to hospitalization for adults with psychiatric conditions, and wraparound services for children with behavioral health needs living in the community); and (3) to expand the capacity of providers delivering home and community-based services and supports (e.g., increase rates for adult day service providers, expand assisted living waiver slots, etc.).

Though these efforts have moved Rhode Island Medicaid in the right direction, the State has not been able to fully re-orient the program to reduce the continued over-reliance on high cost service venues and institutional care across the program. For example:

- Rhode Island has the third highest nursing facility occupancy rate (92.3%) in the nation and, according to one source, a comparatively greater number of nursing facility residents with low levels of acuity than most other states;³
- Due to the absence of Medicaid coverage for home based services, to qualify for needed services and supports, about one percent of the children under the age of 19 in substitute care are voluntarily placed in State custody by parents;
- Average length of stay for psychiatric hospitalizations for both children and adults with behavioral disabilities, though declining, remains higher than the national average as a result of the lack of capacity in community-based alternatives – e.g., supportive housing, step-down services, assertive community treatment; and

³ These figures include private pay residents, but are relevant as over 85% of all nursing facility residents are Medicaid beneficiaries. See: [The Future of Medicaid](#), op.cit , pps.44-48.

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- Current Medicaid payment/program policies do not sufficiently facilitate the ability of maintaining adults with developmental disabilities to remain in their own homes -- i.e., only token financial assistance is available and arranging for and accessing services is far more complicated than if provided in the much more costly ICF/MR or group home setting.

The Global Compact Waiver is designed to address both the causes and consequences of the institutional bias in Medicaid. Toward this end, the State plans to use the additional flexibility provided under the waiver to consolidate its existing Section 1915 (c) waivers to improve efficiency and accountability on the financing side and rebalance the system to achieve greater utilization of less restrictive care settings. This will enable the State to better integrate and coordinate services to high need populations, facilitate the exchange of health information across venues and providers, and give the State the latitude to identify and invest in areas where new provider markets should be encouraged.

More importantly, the State proposes to establish a single assessment organization for Medicaid chronic and long-term care services that will work in collaboration with the systems for managing beneficiaries medical care – health plans and PCCM networks. This unique entity will be responsible for determining level of care needs and developing a service plan that identifies and prices the options open to a beneficiary for obtaining the right services, at the right time in the least restrictive setting. Through this central assessment organization, the State will extend home and community-based services to a broader array of beneficiaries, many of whom are at risk for or already receiving care in expensive residential/institutional facilities (e.g., children in the child welfare system and pediatric hospitals, adults with disabilities in the State’s Eleanor Slater Hospital) due to a lack of capacity in alternative, more appropriate settings. Doing so will not only preserve access to these high cost venues for beneficiaries with the most intensive level of care needs, but also free-up resources to invest in expanding capacity in the service areas where it is lacking the most.

B. THE CONSENSUS FOR REFORM

Since 2000, the three factors outlined here – fiscal cross pressures, service demand, and institutional bias – have colluded to push the State further down the path toward comprehensive Medicaid reform. The consensus for a full-scale redesign of the Rhode Island Medicaid program on the scale outlined in this waiver proposal emerged only recently, however. Though there has been consistent support for system transformation on the long-term care side for over a decade, strategic planning funded through the State’s Real Choices Systems Transformation grants has only recently begun to yield to progress. Similarly, proposals for changing the State’s RItE Care program have tended to be more of the incremental sort and have focused on making adjustments to rather than overhauling or replacing the existing service delivery system.

It has only been over the last year, as the scope of the State’s fiscal crisis became clearer, that support for full-scale reform that extends across populations, programs and delivery systems began to build momentum. The impetus for reform had become an imperative and, at the

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direction of Governor Donald Carcieri, the State agencies sharing responsibility for the Rhode Island Medicaid program began development of the Global Compact Waiver.

1. Development of the Global Compact Waiver

As in most states, the responsibility for administering programs funded in whole or in part through RI Medicaid is shared by multiple health and human services agencies, under the umbrella of the Executive Office of Health and Human Services (EOHHS)⁴, including the single state agency, Department of Human Services (DHS) and the departments of: Mental Health, Retardation and Hospitals (MHRH); Children, Youth and Families (DCYF); Health (DOH), and Elderly Affairs (DEA). Local Education Agencies (LEAs), operating in conjunction with the RI Department of Education, also administer Medicaid financed services.

In the fall of 2007, the leadership of the EOHHS and DHS established an interagency workgroup composed of program administrators, policy experts, and fiscal managers to develop a budget conscious consensus document that used the principles of reform as the basis for redesigning Rhode Island Medicaid. Once the broad contours of the demonstration proposed here began to take shape, the leadership of the five health and human services agencies reached out to key policymakers in the executive and legislative branches and to stakeholders in the community to ask for input and guidance.

By the start of the new year, as the global compact concept was being refined, the central components of the demonstration emerged and analysis of the fiscal implications of the plan and its impact on beneficiaries began in earnest. A Steering Committee, composed of the leadership of the five health and human services department, was established to oversee progress on reform as well as a new set of interagency workgroups, each focusing on a critical component of the plan – e.g., the assessment organization, smart purchasing, choice counseling, etc. A plan for preparing the waiver was developed and a separate group to assist in this process and evaluate fiscal issues was also created. Representatives of the community – providers and consumers – were invited to participate in these groups and continue to do so today.

To assist in implementation planning, experts have been brought in to assess service capacity, map existing and needed resources, and determine the scope of organizational and structural change required for the Medicaid program to meet the targeted goals of reform. The EOHHS has been working with officials across State government to ensure that any related on-going or proposed policy and budget initiatives are integrated into the planning process. Likewise, the State has engaged Medicaid providers interested in participating in implementation design.

2. Public Input

During the course of the 2008 legislative session, the waiver proposal was incorporated into a budget article (Article 17) and was the subject of multiple hearings in the House and Senate. By

⁴ EOHHS Medicaid responsibilities are set forth in See R.I.G.L. 42-7.2-5(a)-(d), specifically.

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the time Article 17 was enacted in mid-June, EOHHS and DHS had presented the waiver proposal to dozens of stakeholders in separate meetings and in three public forums, arranged solely for that purpose. (See a list of these events in Appendix 2.) Questions and concerns raised at these meeting and forums are being compiled and incorporated with their responses in a packet of materials that will be made readily available to the public in hard copy and on the DHS and EOHHS websites. The concept paper explaining the Global Compact has also been posted on these sites.

Questions about the waiver have taken a variety of forms, ranging in focus from concerns about Global Compact's impact on service access in general and for particular populations to much broader issues related to the financial risks to the State. To address these and their own concerns, in Article 17, the legislative leadership formed a process for reviewing the analysis used to develop the financing proposal for the demonstration as well as various other components. This process will continue throughout implementation if the Global Compact is approved.

State Medicaid officials have been in regular contact with their federal partners at CMS and have apprised the Rhode Island Congressional Delegation on both the content of the waiver and progress of seeking federal approval. These activities will continue throughout implementation once the Global Compact becomes a reality.

As a result of these and similar efforts, general support for the Global Compact is broad-based and growing. The agencies that have participated in the development of the comprehensive reform plan are aware that concerns nevertheless may remain and are committed to maintaining an open and active process of engagement with stakeholders, policymakers, and the public.

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Chapter Two: The Proposed Global Compact Waiver

The purpose of this Section 1115 (a) Global Compact waiver is to demonstrate that the State can transform the Rhode Island Medicaid program into a financially solvent and person-centered, opportunity driven, outcomes-based system of coordinated care. Toward this end, the State is proposing to establish a new State-federal compact that provides the State with substantially greater flexibility than available under existing program guidelines in exchange for federal budgetary certainty. The State recognizes this compact significantly alters the nature of the State-federal partnership provided for under Title XIX and that pursuing such sweeping change is not without risks. However, the State is confident that the approval of the Global Compact Waiver will preserve the Rhode Island Medicaid program for future generations while, at the same time, ensuring that every Medicaid beneficiary has access to the right services, at the right time, in the most cost-effective and least restrictive setting.

In designing Global Compact Waiver for this purpose, the State has focused on achieving the following guiding principles for reform:

- ❖ Consumer Empowerment and Choice
- ❖ Personal Responsibility
- ❖ Community-based care solutions
- ❖ Prevention and Wellness
- ❖ Freedom and Independence
- ❖ Competition and Value
- ❖ Pay for Performance
- ❖ Improved Health Information Technology

The State proposes to use the flexibility under the demonstration to translate these core guiding principles into practice through three critical components (1) Rebalancing the long-term care system, (2) instituting mandatory care management across programs and populations, and (3) Fair Share -- pursuing smart payment and purchasing strategies in several key, high cost areas. Each of these three components and the role they play in furthering the purpose of the demonstration are explained below.

A. COMPONENT I --Rebalancing the Long Term Care System and De-Institutionalization across the Spectrum

Rhode Island's long-term care system is heavily based on nursing home care, residential care and high-end services in restrictive and costly venues. Through this Global Compact change initiative, the State proposes to rebalance the system in favor of community-based care by diverting prospective admissions, transitioning beneficiaries whenever appropriate and feasible and developing care setting and service alternatives. The goal of this facet of reform is to move towards a 50/50 split in the total dollars spent for beneficiaries receiving services in institutional and residential high-end placements versus less restrictive, but care appropriate settings in the community by 2013.

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The component of the demonstration reflects the State's commitment to implement a service delivery system that encourages individual self-determination, family direction/involvement, interagency collaboration, and individual choice through the provision of highly specialized and individually tailored home-based services. As such, the State's goal is to encourage the self-determination of all individuals receiving services, and draw on natural support systems wherever possible. Through formal and structured interagency collaboration in determining the needs for and scope of services, the entire community-based service delivery system for all individuals will improve, and ultimately, ensure that each person receives the best possible combination of age-appropriate services and supports.

1. Restructuring the Long Term Care (LTC) System

To achieve balance in Rhode Island's long-term care system, the paradigm must shift to eliminate the existing institutional bias in long-term care and create the infrastructure for a person-centered system that provides a broad array of community-based care choices. The Global Compact Waiver will achieve this shift by enabling the State to use its flexibility to reduce reliance on high-end institutional placements, expand available and effective community-based services, and empower beneficiaries and their families to determine the most appropriate setting for their care.

a. Level of Care and Service Determinations

Two of the most significant changes to be implemented with the additional flexibility provided to the State under this proposed demonstration are: (1) the consolidation of the State's various Section 1915 (c) Home and Community Based Service (HCBS) waivers; and (2) the development and implementation of a new three-tier level of care determination process. Both the consolidation of the State's HCBS waivers and the further refinement of level of care determinations are essential for assuring that every beneficiary requiring long-term care is able to access the right services in the most appropriate setting regardless of the basis of eligibility for services. Access to primary and acute health care is not impacted by these levels of care determinations.

To replace the current single level of care determination, Rhode Island will draw on elements from the successful long-term care initiatives of other states that utilize a system for determining the scope of necessary services through an assessment of the need for an institutional level of care -- i.e., nursing facility, Intermediate Care Facility for Mental Retardation (ICFMR), and hospital. The service tiers developed through an interagency collaboration are as follows:

- ❖ The *highest level of care* will be reserved for nursing home and residential treatment facilities. Beneficiaries meeting this level of care will also have the option to choose community-based care, including an extensive menu of services and supports.
- ❖ A *high level of care* will allow the beneficiary access to an array of community-based core services, including but not limited to shared living, assisted living and home care services and supports.

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- ❖ *A preventive level of care* will enable beneficiaries to receive services targeted at preventing re-admissions or reducing lengths of stay. Funding will be established for a service package that will include such items as homemaker services, home modifications or physical therapy services.

The matrix presented in Figure 2.1 shows the types of services that will be available to beneficiaries within each of the three newly defined levels of care:

Figure 2.1: LTC Proposed Level of Care and Service Option Matrix		
Highest Nursing Home Level of Care (Access to Nursing Facilities and all Community-Based Services)	Highest Hospital Level of Care (Access to LTC Hospital, Group Homes, Residential Treatment Facilities and all Community-Based Services)	Highest ICFMR Level of Care (Access to ICFMR, Group Homes and all Community Based Services)
High Nursing Home Level of Care (Access to Core and Preventive Community-Based Services)	High Hospital Level of Care (Access to Core and Preventive Community-Based Services)	High ICFMR Level of Care (Access to Core and Preventive Community-Based Services)
Preventive Nursing Home Level of Care (Access to Preventive Community-Based Services)	Preventive Hospital Level of Care (Access to Preventive Community-Based Services)	Preventive ICFMR Level of Care (Access to Preventive Community-Based Services)

Core services will be available to beneficiaries that meet the criteria for the highest level of care at all times and to those qualifying at the high level of care group, but only to the extent funding is available. Preventive services will be available to the highest level of care group at all times and to the high and preventive level of care group, but again only as long as adequate funding is available.

The Core and Preventive Community-based Services are identified below in Figure 2.2:

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Figure 2.2: Medicaid Reform: LTC Core and Preventive Services

Core Services		Preventive Services
Personal Care Services	Service Coordination	Homemaker Services
Home Health Services	Assisted Living	Minor Home Modifications
Home Modifications	Medication Management	Respite
Companion Services	Meal on Wheels	Physical Therapy Evaluations
Supportive Employment	Adult Day Care	Home-Based Treatment Services
Personal Emergency	Shared Living	
Response Systems	Assistive Devices	
Adult Day Programs	Family Support	
	Behavior Management	
	Case Management	

b. Assessment and Coordination Organization

To ensure beneficiaries served under the Global Compact have access to the appropriate services in the appropriate setting, the State is establishing an interagency long-term care Assessment and Coordination Organization (ACO), under the umbrella of the Executive Office of Health and Human Services. The purpose of this centralized assessment organization is to streamline the intake and assessment processes and provide beneficiaries and their families with clear, concise and accurate information about their care options.

The ACO's chief function will be to serve as the service access point for beneficiaries and their families who are in need of or already receiving long-term care. As such, beneficiaries requiring acute care services through RItE Care and RItE Share or one of the care management systems for adults (Rhody Partners or Connect Care Choice) will not be required to participate in the ACO.

Specifically, the Assessment and Coordination Organization will be responsible for providing the following to prospective and current long-term care beneficiaries:

- ❖ Conducting assessments for determining level of care needs;
- ❖ Determining level of care;
- ❖ Developing service plans with beneficiaries and their families;
- ❖ Pricing a service budget, authorizing services, and developing a voucher when appropriate;
- ❖ Making referrals to appropriate settings;
- ❖ Reviewing progress and re-authorizing, modifying or focusing access to services based on the client's feedback and changing needs;
- ❖ Coordinating services with care management entities;

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- ❖ Training and educating consumers, discharge planners and providers in coordination with other on-going efforts in this area;
- ❖ Tracking utilization and monitoring outcomes;
- ❖ Conducting interdisciplinary high cost case reviews; and
- ❖ Offering choice counseling to beneficiaries and their families.

As part of the eligibility determination process for long-term care or community support services, Medicaid beneficiaries will receive through the ACO both a targeted assessment and individualized “choice” counseling to assist them in making reasoned decisions about their care options. Current Medicaid beneficiaries who are at risk or develop the need for either intensive residential services (nursing home/ group homes/ child residential) or community support services will also be assessed by the ACO.

The ACO’s Choice Counseling program is designed to provide beneficiaries with the information necessary to make educated choices about their care. The ACO will include choice counselors who have experience with special populations. The choice counselors will explain the nature of the global waiver to beneficiaries, as well as their rights around participation, access to service and appeal, and help them choose a plan of care. Accurate information about prices, utilization and quality will be available routinely through the ACO to ensure transparency and ease of access. To both enhance choice and promote personal responsibility, beneficiaries also will be provided with health reports that indicate how much they have spent on their health care and where so they can self-evaluate whether their dollars have been spent well.

It is important to note that the State’s *Aging and Disability Resource Center* (ADRC) – The Point -- will be an integral component of the ACO. The Point will continue to play a crucial role in providing information and referrals and take the lead in implementing the new Choice Counseling program. As The Point serves all elders and adults with the disabilities, Choice Counseling will also be available to members of this population requiring services on the acute care side. For example, such counseling will be provided to assist adult beneficiaries when choosing a care management system – health plan or PCCM. As the role of The Point expands, so too will its capacity to work in collaboration with the ACO staff responsible for processing eligibility, developing service plans, and tracking service demand and utilization. Additionally, the State is currently pursuing a Real Choices Systems Change grant focusing on broadening the capacity of The Point for beneficiaries requiring behavioral health services.

The State plans to develop an algorithm to assist the ACO in making determinations of care and service needs that is tied into information provided through the CHOICES MMIS Module now under development as well as to the State’s health information exchange system. Both of these efforts are being financed in whole or in part with Medicaid grants and will be integrated, as appropriate, into the Global Compact Waiver.

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Centralizing responsibility for determining the scope of care and service level through a single interagency process is designed specifically to shift the loci of decision-making away from providers and to beneficiaries and their families. As such, the ACO will not only assist in drawing a clearer delineation between the payers and providers in the design and implementation of a service plan, but it will also further the long-range objective of reform to break the stronghold providers have over the scope and setting of beneficiary services.

Universal functions of the ACO such as training, staff meetings, stakeholder education, assessment tool reviews, and outreach initiatives will be coordinated by EOHHS. Contracted community-based providers will continue to provide ongoing case management for beneficiaries with periodic reviews by the Assessment and Coordination Organization. EOHHS will have the option to issue an RFP to solicit vendors to support the training of community – based providers and to assist in the monitoring of service plans.

The establishment of the ACO does not require federal waiver authority. However, the State is proposing to use the flexibility under the demonstration to enable the ACO to use the assessments as the basis for establishing individual budgets, power accounts, and determining access to certain services. The latitude to implement this innovative aspect of the ACO is not only critical for achieving the goals of reform, but for the overall success of the demonstration as well.

c. Service Delivery System

Institutional and community-based long-term care services will be delivered in three ways:

- ❖ Fee-for-service: Beneficiaries will be able to access long-term care services in the same way that services are accessed today, through a fee-for-service system. Under this system, a beneficiary can choose the agency or provider to deliver the service(s). In turn for those services requiring authorization or that is “out-of-plan”, the agency/provider bills the Medicaid agency for services authorized by the ACO and/or the health plan or PCCM network.
- ❖ Self-direction: Beneficiaries and their families will also have the option to purchase personal assistance services (including, but not limited to aid in daily living tasks such as bathing, dressing, toileting, meal preparation) through a self-direction option. Under this option, beneficiaries will work with the ACO to develop a budget amount for services needed. The beneficiary, with the support of a fiscal intermediary, will then be able to purchase services directly. This option is based on experience from Rhode Island’s 1915(c) Cash and Counseling Waiver (*RI Personal Choice*), 1915(c) Developmental Disabilities Waiver, and Personal Assistance Service and Supports program. Self-direction will also be implemented through a High-Fidelity Wraparound process for children in residential treatment who are transitioning back to a home-based setting. Families will play a leading role in service design by selecting from a menu of options that address the child’s behavioral health issues and support system.
- ❖ Limited Funding: Beneficiaries assessed to be at the high level of care will have access to core and preventive community-based services (homemaker services; moderate home

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modifications; respite; and physical therapy evaluations) on a limited basis. Beneficiaries assessed at the preventive level of care will have access to preventive community-based services on a limited basis. These services will be available to individuals at these levels of care based on available funding. The State will determine if the limits will be set on a service basis or an individual basis.

2. Expanding Capacity

The success of Medicaid reform for Rhode Islanders will depend, in large part, on improving the availability and effectiveness of community-based service providers and programs. With the onset of an ambitious nursing home and residential care diversion and transition effort, Rhode Islanders returning to the community and remaining in the community will present with complex medical, social, functional, and/or cognitive needs. The State's ability to transform the guiding principles of Medicaid reform into practice and ensure that every beneficiary receives the right services, at the right time and in the right setting, is thus contingent on its ability to make the services required to meet these needs readily accessible.

Accordingly, as part of the effort to meet the anticipated increased demand for community services, the State has designed a comprehensive, detailed plan, with the assessment and care coordination organization at its core, for the expansion of existing programs and services and the introduction of innovative and flexible community supports. This plan will provide a mechanism to build upon and support the critical principles articulated in the Perry/Sullivan Long-Term Care Service and Finance Reform Act (R.I. Gen. Laws sections 40-8.9-1 through 6; Perry-Sullivan Act). These objectives also dovetail with several of the central tasks currently underway as part of the State's Real Choices System Change (RCSC), long-term care restructuring grant. In general, the essential instruments the State will be using in the capacity building process include:

- ❖ Expanding the flexibility of community providers to include programs such as adult day services and home delivered meals on weekends and holidays;
- ❖ Broadening the service categories for Medicaid reimbursement to include such services as medication management, flexible transportation, fall prevention training, home-based behavioral supports and other services that will be provided in supportive housing options like supervised apartments and shared living;
- ❖ Increasing the availability of community service providers through a combination of rate increases, performance and business redesign incentives, credentialing standards, and by supporting training and education opportunities targeted towards populations with special needs, persons who speak a language other than English or come from diverse backgrounds;
- ❖ Extending adult day service options by raising rates and tying them to performance i.e., expanding operating hours to seven days, developing greater capacity, and broadening services to include higher levels of acuity;

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- ❖ Expanding the use of various self-directed care models for beneficiaries including cash & counseling, service vouchers, money follows the person, wraparound service plans with flexible funds, and any other options that may emerge that increase access to a wider range of community-based services and supports for persons with special needs and their families;
- ❖ Developing transitional support services;
- ❖ As part of the ACO, adding more and a greater variety of outlets for counseling beneficiaries about their community-based options by including hospitals, nursing homes, and physicians' offices;
- ❖ Providing financial incentives/rewards to health care professionals who promote and utilize community-based services for their patients;
- ❖ Supporting State-funded programs that serve a Medicaid enrollment diversion function – e.g., maintain beneficiaries in the community and delay admissions to institutionally-based or high cost residential care;
- ❖ Building public investment and participation through provider/advocate meetings and consumer focus groups to ensure service oversight and quality; and
- ❖ Coordinating with faith-based organizations to perform chore services (e.g. cutting grass or shoveling snow; pharmacy and grocery deliveries; budget management, etc.) by creating a stable of volunteers to provide these services to beneficiaries living in the community.

3. Rate Restructuring

A major obstacle to the goal of expanding capacity in the community-based services system is the inability of providers to compete for qualified workers. Medicaid's historically low payment rates and reimbursement methods have only served to exacerbate this problem.

To further the goals of reform, the State will also be looking at this review and the results of a comprehensive mapping of resources to determine where the service gaps exist in the continuum of care and how the State might use incentives and smart purchasing to drive the market in these areas. Comprehensive resource mapping is being performed as part of the State's Real Choices Systems Change, LTC grant. Under the proposed demonstration, the State will have the flexibility to reinvest a portion of any savings derived from reducing reliance on high cost care venues to broaden the range of available service setting choices.

An additional challenge to rebalancing the system is that federal matching funds are not uniformly available for many of the expenses attendant to transitioning beneficiaries back into the community (e.g. rental deposit, utility connection costs, minor home modifications, etc.). As part of this demonstration, the State proposes to utilize all of the Medicaid options other states

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have used to cover these transition expenses -- i.e., administrative expenditures, waiver authority – as well as the following:

- ❖ An immediate *prospective* base adjustment to rates paid for homemaker, adult day services, and personal care (home health aide) services across all departments and programs, of an amount between five (5%) and ten (10%) of the existing standard or average rate, contingent upon a demonstrated increase in the state-funded caseload of ten per cent (10%) by June 30, 2009;
- ❖ Institute targeted rate increments for all of the subject services to encourage service specialization and scheduling accommodations, including, but not limited to, medication and pain management, wound management, certified Alzheimer's Syndrome treatment and support programs, and shift differentials for night and week-end services;
- ❖ Development of a rate-setting methodology for community-based services that assures coverage of the base cost of service delivery as well as reasonable coverage of changes in cost caused by inflation – particularly wage inflation;
- ❖ Upon obtaining the necessary legal authorization, establish hospital diagnostic related groups (DRGs) and acuity-based nursing facility rates, as appropriate;
- ❖ Explore the opportunities for providing financial incentives to providers to reduce excess/unneeded capacity;
- ❖ Establishment of a fund to pay for the non-Medicaid reimbursable expenses necessary to transition residents back to the community not to exceed an annual or per person amount; and
- ❖ Application of a developed rate or rate structure for each service where applicable to Medicaid waiver services and the associated State- only programs.

The State's goal is to provide sufficient incentives to increase the number of approved community-based providers and is committed to expanding the range of related service options for elders and adults with disabilities, as well as for children with special and/or therapeutic needs. Absent a sustained effort to increase the availability and range of these options, reliance on high cost service venues will continue.

4. Transitioning and Diverting Beneficiaries into the Community

Over the next few years Rhode Island will be transitioning and diverting hundreds of its citizens into lesser restrictive settings. In general, the State is committed to ensuring the beneficiaries and their families are involved in the process of transition planning and are aware fully of the options open to them.

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Each State agency responsible for the populations targeted for transition/diversion faces a unique set of challenges. For example, as the State has succeeded in transitioning over a hundred elders from the nursing home setting just in the last year, the ACO's capacity to drive the diversion plan now under development is critical.

The principal challenge for transitioning children is providing the right mix of incentives to vendors that will ensure beneficiaries moved from high cost venues to family and community settings have ready access to necessary services. Equally important in this arena, is expanding waiver eligibility to families who currently voluntarily relinquish custody of their children for placement in substitute care so necessary Medicaid funded services can be accessed. Similar challenges face the State in moving beneficiaries with developmental disabilities and serious mental illness from intensive residential and institutional settings. Often, these are the only care settings covered by Medicaid and/or the sole care venues that provide the services needed in a secure setting.

In order to achieve the right services at the right time across the spectrum, Rhode Island recognizes that a number of the rebalancing concepts apply to the community behavioral system. Service delivery restructuring and behavioral health integration with the ACO will enhance the transparency of service eligibility. The emphasis on transitional and recovery based services will expand capacity to move individuals from psychiatric hospitals, institutions, group homes and homelessness to alternative living settings (e.g. supported housing or shared living).

B. COMPONENT II--Care Management

One of the central goals of the Global Compact Waiver is to reorient the Medicaid program to reward responsible personal choices, prevention and wellness. All play an important role in reducing the need for long-term care and the over-reliance on high cost venues when feasible and appropriate. Care management, with its emphasis on optimizing and maintaining health, is an important tool for moving the program in this direction. Therefore, under the proposed demonstration, each beneficiary will have:

- ❖ Access to appropriate services and an accountable medical home that provides support in coordinating/managing services and assistance in system navigation; and
- ❖ Personal responsibility for decisions about their care and access to the information required to make reasoned care choices.

For the purposes of the proposed demonstration, a person-centered medical home provides comprehensive primary care that facilitates partnerships between beneficiaries, their personal physicians, other healthcare professionals and community providers and, when appropriate, the beneficiary's family. The State has developed a two-prong strategy designed to further this goal that includes implementing mandatory care management and power accounts.

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1. Managing Care Across Populations

The State proposes to use the flexibility afforded under the Global Waiver to require all Medicaid beneficiaries without third party healthcare coverage to enroll in a managed care plan or in a primary care case management (PCCM) plan. Children and families, including children with special health care needs and children in substitute care, will be required to enroll in one of several RItE Care managed care plans. Elders and Adults with disabilities will have the choice of enrolling in one of the Rhody Health Partners managed health plans, PACE or a Connect Care PCCM. Medicaid beneficiaries with access to cost-effective third-party health coverage will be required to enroll in RItE share, the State's premium assistance program or a similar State program. This applies to beneficiaries eligible for RItE Care who have access to employer sponsored health insurance (ESI), as well as adults with disabilities who are qualified for coverage under the ESI of a parent/guardian.

The care management options are outlined in Figure 2.3 below:

Figure 2.3: Care Management Options By Populations		
	Health Plan	PCCM
Beneficiaries Served:		
<ul style="list-style-type: none">• Children & Families• Children with Special Needs• Children in Substitute Care	<ul style="list-style-type: none">• RItE Care Plans• RItE Share	May include: <ul style="list-style-type: none">• Connect Care Plus (for high cost cases)
<ul style="list-style-type: none">• Elders• Adults with Disabilities	<ul style="list-style-type: none">• Rhody Health Partners• PACE	<ul style="list-style-type: none">• Connect Care Choice• Connect Care Plus (for high cost cases)
The dually eligible population (Medicare/Medicaid) will have the option to enroll in a Special Needs Plan or PACE		

The State will utilize contracts with these entities to promote personal responsibility, prevention, and wellness by building on, re-engineering and expanding upon long established and newly developed program options, including RItE Care, Connect Care Choice and Rhody Health Partners. The State is committed to increasing the use of trained paraprofessionals (e.g., health coaches, parent consultants, etc.) in all of these options to assist beneficiaries with care coordination, system navigation, and accessing community based services. In combination, these initiatives help fulfill the commitment that cost effective, person centered care management is in place for all Medicaid beneficiaries.

Under the mandatory system, Medicaid beneficiaries will have a medical home and will have access to services designed to meet their needs as well as to a level of care coordination that might otherwise be unavailable, particularly for those beneficiaries who are living on their own in the community. It is important to stress here that though care management systems are by

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their very nature acute care oriented (i.e., emphasize primary care, preventive, and wellness), there will be a nexus to the long-term care system through the ACO and community case managers. Providing a medical home will also ensure that health coverage and services are used at the right time and in the right setting. Implementing care management instruments across populations increases the opportunities significantly for more efficient monitoring of access and quality, greater use and efficacy of performance-based payment incentives and improved cost effectiveness through value-based and smart purchasing.

a. Mandatory Care Management for Adults

RI Medicaid has developed two care management options for adults with disabilities and chronic conditions to enhance cost effectiveness, care coordination, wellness, and improve quality of care. These are Connect Care Choice and Rhody Health Partners. To date, enrollment in both of these two options has been voluntary, and only for non-dually eligible beneficiaries. As a result, a segment of the populations of elders and adults with disabilities who are not dually eligible has not enrolled and remains without care coordination and care management. Under the proposed demonstration, enrollment in a care management option will become mandatory for all adults without third-party coverage. Choice Counseling through The Point will be provided at the time of application for new beneficiaries and at staggered intervals for current beneficiaries to assist individuals and families in evaluating their care management options.

The State considers mandatory enrollment in a care management system as an important opportunity to integrate pay-for-performance principles into the Medicaid program. Accordingly, the State will use its authority under the Global Compact waiver to restructure the payment system for Medicaid providers and health plans to provide rewards to health plans and providers that achieve better and more cost-effective outcomes through care management.

Primary Care Case Management: Connect Care Choice

The Connect Care Choice program has established a system of the Primary Care / Nurse Case Management (PCCM) networks composed of medical practices and other care settings that have adopted the chronic care model developed through the Rhode Island Chronic Care Collaborative. (The collaborative is a Robert Wood Johnson funded initiative, facilitated by the Quality Partners of Rhode Island, partnering with the RI Department of Health's Diabetes Prevention and Control Program with other related statewide initiatives).

Practices using this chronic care model provide a medical home, nurse case management, primary and preventative care and support for self-directed care management. Self-management skills are especially necessary to help beneficiaries who are chronically ill and/or living with disabilities gain confidence in their ability to maintain independence, gain control over their chronic conditions, and assume greater personal responsibility for their health with the necessary social and medical supports.

By design, this model of health care delivery is holistic in approach and begins with an overall evaluation in which each beneficiary is stratified as low, moderate, or high risk based on acute

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hospital and ED utilization, chronic diseases/illnesses and, and co-occurring behavioral health conditions. Practices participating in the Connect Care Choice program networks cross all settings of care and include, but are not limited to, private group practice, community health centers, and hospital based ambulatory clinics.

Rhody Health Partners

Through Rhody Health Partners, Rhode Island Medicaid offers a comprehensive, integrated set of benefits to elders and adults with disabilities. The eligible population is community based non-dual adults. Initial enrollment in this optional managed care program began on April 1, 2008. Participating health plans are United Health Care of New England and Neighborhood Health Plan of Rhode Island.

Each beneficiary enrolled in Rhody Health Partners (RHP), receives an initial health screen, conducted by a member of an interdisciplinary care management team. The goal of the initial health screen is to assess the member's current utilization of services, and determine whether the member has needs that are not being met – medical, social, or behavioral. Upon completion of the initial health screen, the member is included in short-term, long-term or intensive care management, depending on their needs. Health plan care management staff work closely with members to ensure their input into the care plan, and encourage independent living and decision-making.

Care managers also coordinate out-of-plan benefits including waiver long-term care services and care options for beneficiaries with severe and persistent mental illness. Each health plan offers a large network of primary care, specialty care, and behavioral health providers. Health plan customer service staff will assist the members in finding a provider, accessing transportation or interpreter services, and help answer benefit-related questions. Health plans provide handbooks and newsletters to their members in order to educate them on topics like wellness, preventive care, and appropriate emergency room use.

Dually Eligible Beneficiaries

As noted above, the State's proposal for requiring mandatory enrollment of adult beneficiaries in managed care excludes those who are dually eligible for Medicaid and Medicare. The dual eligible population includes many of the most frail and impoverished beneficiaries in the State's Medicaid program; not surprisingly, dual eligible beneficiaries tend to be the highest cost cases in both the Medicare and the Medicaid programs. For seniors and people with disabilities who receive full Medicaid coverage, Medicare is the primary insurer and payor for most hospitalization and medical services. Medicaid as the supplemental insurer generally pays for some or all of Medicare's cost-sharing and for services such as non-skilled long term care, nursing homes, transportation, durable medical equipment, personal care services and - until January 1, 2006 - prescription drug coverage.

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Given the needs of the dual eligible population and the costs of meeting them, Rhode Island is very interested in developing a partnership with the federal government that will facilitate better care management and coordination of services. The State would like to enter into a dialogue with CMS about the possibility of including as part of the proposed Global Compact waiver demonstration project a unique component that will enable the Rhode Island Medicaid Program to work in collaboration with the Medicare program in the development of a person-centered integrated model of care for dually eligible beneficiaries. Central features of this component are as follows:

- ❖ The voluntary enrollment of Rhode Island dually eligible beneficiaries in the Connect Care Choice program with Medicare financial participation. This will provide dually eligible Rhode Islanders with another option for a coordinated care system across the spectrum of ‘acute, sub-acute, chronic, and long-term care’ settings that offers the right services, at the right time in the right setting;
- ❖ An assessment and service plan tailored to each beneficiary’s unique level of care and service needs by the Assessment and Coordination Organization;
- ❖ The re-investing of Medicare savings into the development and expansion of home health care services;
- ❖ Enable the Medicaid program to gain access to Medicare claims and encounter data; and
- ❖ Authorization for the Medicaid single state agency to operate as a Part D plan, so dually eligible beneficiaries can voluntarily enroll.

Rhode Island is aware that the negotiation of this component of the demonstration proposal will require far lengthier analysis and further review, and will include parties other than the Center for Medicaid and State Operations. The dual eligible component of the proposed waiver is outlined here to illustrate the State’s commitment to include every facet of the Medicaid program in this proposed global waiver demonstration, if not immediately then in the long-term. The State’s goal is to obtain federal authorization to include the dual eligible component as an amendment to the Global Consumer Choice Compact waiver.

b. Mandatory Enrollment of Children with Special Health Care Needs in Managed Care

Since SFY 2004, children with special health care needs (CSHCN) have been enrolled in RItE Care managed care on a voluntary basis. Currently, just under half of the children in this population are RItE Care members – about 4,700. Of the children who have not enrolled, about half are ineligible for RItE Care because they have commercial health insurance. Under the demonstration proposed here, the State plans to require all children in the CSHCN population without private coverage to enroll in RItE Care – i.e., the remaining approximately 2,400 children with special health care needs in fee for services in this voluntary program.

CSHCN enrollment in managed care has been voluntary to this point due to the participation of only one plan (Neighborhood Health Plan of Rhode Island); current federal guidelines specify that, without waiver authority, mandatory enrollment requires that beneficiaries have a choice of plans – i.e., at least two participating plans. The State is currently in negotiations with a second plan to cover the CSHCN population. In the event these negotiations stall of fail, the State plans

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to use the flexibility provided under the Global Compact to begin mandatory enrollment in managed care for all beneficiaries in the CSHCN populations. Over the course of the demonstration, the Connect Care Choice system may be expanded to include pediatrics, thus giving the families of children in the CSHCN population choice, at a minimum, of either a managed care or primary case management option as well.

2. Healthy Choice Accounts

One of the central goals of the Global Compact is to promote greater personal responsibility for health care. Thus, assuring beneficiaries have the opportunity to better manage their own health care is crucial. Health Opportunity Accounts (HOAs) and beneficiary-controlled incentive plans are among the vehicles now open to Medicaid beneficiaries that not only enable them to exercise greater control over their care, but also provide incentives and rewards for healthy behaviors.

The flexibility for the states to establish HOAs was created as part of the Federal Deficit Reduction Act of 2006. South Carolina and Indiana have both adopted variations of the HOA in their Medicaid programs with significant success. Rhode Island is among a number of other states proposing to use the HOA model to increase beneficiary participation in decisions about their own care. During the demonstration, we may seek the flexibility to establish HOAs for higher-income groups.

The State is proposing to create incentive plans for a broader range of Medicaid beneficiaries, to be called the Healthy Choice Account or HCA, using the concept to encourage healthy choices and increase the information available to beneficiaries about their health care expenses. Specifically, all Rhode Island Medicaid beneficiaries will receive a periodic report that itemizes both the types of services they received and their costs. This information will make Rhode Island Medicaid beneficiaries more aware of their health utilization trends and, in doing so, serve as a source of education and encouragement for healthy lifestyle choices. Specific populations will be given the opportunity to earn rewards and as additional funding becomes available other populations will be given the opportunity to earn awards as well.

For example, each family member with a HCA will be eligible to receive up to 100 points per year by engaging in targeted healthy behaviors. The proposed target behaviors include:

- No Emergency Department (ED) use for ambulatory care sensitive conditions that could have been treated in a primary care doctor's office (+25 points each 6 month period)
- Completion of an annual Health Risk Assessment (+25 points annually)
- Annual physical exam by a primary care doctor (+25 points annually)
- Each use of the ED for ambulatory care sensitive conditions that could have been treated in a primary care doctor's office (-25 points each episode)

Each family member who earns 100 points per year will receive a reward, ranging from a gift card for health related goods to a one month premium holiday – e.g., no payment due.

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The use of HCAs is consistent with the guiding principles of Medicaid reform set forth earlier and an important element of the demonstration over the life of the waiver. The State is confident that HCAs will assist in reducing the over-reliance on high cost venues like the ED and provide beneficiaries with a new avenue to exercise greater control over the cost-effectiveness of their health care.

C. COMPONENT III-Fair Share: “Smart” Payments and Purchasing

One of the chief goals of reform, and thus of the Global Compact demonstration, is to achieve the best value for every Medicaid dollar the State spends. To realize this goal, the State plans to use the flexibility provided under the waiver to leverage Medicaid funds to attain the best possible health outcomes. On the beneficiary side, the State will make greater use of cost-sharing to encourage more responsible and cost-effective utilization, promote personal accountability and deter crowd-out, and reward healthy choices and wellness. Under the demonstration on the provider side, the State will introduce the principles of selective “competitive” contracting to ensure Medicaid obtains the best price and value when purchasing services for beneficiaries. Both of these strategies are designed to shift the focus of the RI Medicaid program

1. Smart Premiums and Co-pays: Enhancing Personal Responsibility and Accountability

For the purposes of the Global Compact waiver, a smart premium or co-pay is a form of cost-sharing that is “outcome” oriented rather than a means of shifting or distributing program costs. Since SFY 2000, RI Medicaid has considered requiring beneficiaries to pay a fair share of the cost for coverage is an important mechanism for increasing each individual’s investment in and personal responsibility for health services and coverage.

Given this premise, as the costs for Medicaid coverage rise, so too should the contributions of beneficiaries within certain income limits. Moreover, as Medicaid coverage was not intended to be a substitute for commercial insurance, it is important that beneficiary cost sharing reflect – albeit at lower levels – other forms of health coverage. Benefits available to most Medicaid enrollees – particularly on the children and family side – are more comprehensive than most plans in the commercial market. For the segments of this population that churn in and out of Medicaid as their employment status changes – primarily parents – tailoring benefits to be comparable to predominant forms of employer-sponsored insurance prevents substitution and promotes responsible utilization of ancillary services.

Outlined below are proposals for smart payments -- premiums and co-pays -- the State plans to implement under the demonstration that assure all beneficiaries who are able pay a fair share of the costs of Medicaid coverage.

a. Raise RIte Care Premium Rates to a Full 5% of Income

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Current waiver authority with CMS and RI General Law allows the State to raise monthly premiums charged to RItE Care families at or above 150% to a maximum of 5% of income. At present, premiums are set at 3-4% of monthly income (\$61, \$77 and \$92 depending on income level). Rates were last raised in August 2002. As indicated Figure 10 below, new rates under the Global Compact waiver would be \$86, \$106 and \$114 for the three tiers.

Figure 2.4: RItE Care 5% Premiums Under the Demonstration					
% of FPL	# of families	Assume 5% reduction of families	% at premium level	Old premium rate	New Smart premium rate
150-185	3,555	3,377	63%	\$ 61	\$ 86
185-200	703	668	12%	\$ 77	\$106
200-250	1,403	1,333	25%	\$ 92	\$114
Total	5,661	5,378	100%		

b. New RItE Care Premium Rates at 3% of Income for Families 133-150% FPL

Current waiver authority with CMS would allow the State to implement cost sharing for families between 133% and 150% of the Federal Poverty Level (FPL) at 3% of income (\$45 per month).

Figure 2.5: RItE Care 3% Premiums Under the Demonstration		
FPL	# of Families	New Premium
133-150% FPL	2188	\$ 45

c. Co-pays for RItE Care Populations

Currently in the RItE Care waiver, we have the authority to charge families at or above 133% FPL premiums up to 5% of income as well as certain co-pays. In the waiver proposal, we would also seek additional authority to charge co-pays for families below 133% FPL. This proposal could require RItE Care beneficiaries to pay the following co-pays during the demonstration period:

- Emergency Department Visits for Ambulatory Care Sensitive Conditions that could be treated in a doctor's office; and waived if admitted.

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- \$3 per ED visit for all children and parents 0-150% FPL
- \$25 per ED visit for all children and parents above 150% FPL
- Prescription Co-pays
- \$0 for generic drugs regardless of FPL
- \$3 for brand name drugs regardless of FPL

In addition to implementing these smart premiums and co-pays, the State also plans to use its flexibility under the waiver to streamline the benefit package for parents at or above 100% of the FPL. This may entail eliminating certain health benefits including Dental, over the counter (OTC) drugs, and podiatry benefits for parents above 100% FPL currently enrolled in RItE Care. The goal of this effort would be to more closely align benefits for parents above 100% FPL with commercial health insurance benefits.

d. Additional Initiatives

The State plans to implement several additional initiatives in this area that do not require federal waiver authority. First, the State plans to mandate that all Rhode Island participating Medicaid providers and vendors to furnish information about the employer sponsored insurance plans they offer. This will provide the State with the information necessary to enroll Medicaid eligible applicants and beneficiaries who work for these providers into the RItE Share premium assistance program when appropriate. Currently, the State requests information about employer insurance from beneficiaries at application and recertification. Under State law at present, the Medicaid program does not have the authority to require that employers provide this information.

A second initiative that State will implement expands the third party liability (TPL) information RI Medicaid currently receives via the commercial insurance tape match. Access to more timely and accurate data will enable the State to transition more families from RItE Care to RItE Share. and maximizing the use of the employer's contribution to health insurance.

2. Smart Purchasing

Smart purchasing involves contracting upfront with a vendor, provider or other entity that accepts payment for an agreed upon price for a specified service or range of services for Medicaid beneficiaries. As the purchaser, the State will set standards related to quality and outcomes that the contracting entity is obligated to follow and for which it is ultimately held accountable. The State thus will have greater capacity to target services for all beneficiaries, a population or even a single coverage group when using this strategy. Moreover, the State can use "selective contracting" with one or multiple entities to stimulate competition and guarantee the best price.

At present, the way services are purchased in much of the Medicaid program does not promote competition among hospitals and other providers. As a result, the State is paying a wide range of rates for basically the same services and level of care. Smart purchasing will not only allow for one consistent rate, but it will also be tied to quality performance measures that ensure the State

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achieves the best health outcomes for every Medicaid dollar it spends. Additionally, smart purchasing is essential to achieve the broader reform and demonstration goal of making Medicaid “person” rather than “provider” centered, and to the extent feasible, market driven.

Under the Global Compact waiver, the State proposes to use the principles of smart purchasing to institute selective contracting for psychiatric inpatient beds and out patient non-urgent services. Other areas of selective contracting will be initiated gradually, where appropriate, but only if quality and access can be maintained. The State will make information about service utilization, actual expenditures and specified outcomes achieved available to the public, so that all interested parties, including health care providers, beneficiaries, and legislators will be able to evaluate the benefits of this purchasing strategy.

a. Psychiatric Services

Currently, the State uses state-only dollars to purchase psychiatric in-patient care for uninsured individuals. This is an expensive system, which creates a fragmented network for insured and uninsured individuals. The selective purchasing of Medicaid psychiatric in-patient beds will integrate the uninsured into the purchase of services for Medicaid beneficiaries. Blending the populations by integrating the procurement process will yield substantial saving and, more importantly, provide one comprehensive system of care with unified outcomes rather than a two or three-tiered system.

Rhode Island is exploring modifying its current hospital reimbursement system and is looking at implementing a DRG system of reimbursement. A Hospital Task Force has been established to explore this reimbursement methodology. During this process a small number of diagnoses have been identified as ‘outliers. For example, mental health has been a challenge for DRG developers. Lengths of stay for these diagnoses are not always predictable and, as a result, a number of states carve out or make “outlier” payments for mental health and substance abuse treatment. For FY 2006 Rhode Island Medicaid inpatient claims, the top 5 diagnoses categories by payments were for mental health. These payments across community hospitals exhibited a large variation in average cost per stay. The differences variances are not surprising given the current negotiated reimbursement system. The State specifically will issue requests for proposal for the inpatient hospital services that are not recommended as an appropriate component of the Hospital Task Force DRG system.

Hospital outpatient reimbursements exhibit the same variations for selected ambulatory surgeries. For example, tonsillectomies range from \$720 to \$800. These procedures will be added to the selective purchasing of inpatient service outliers.

b. Pharmacy Services

Rhode Island proposes to implement a number of initiatives that will help contain the growth of pharmacy expenditures. These actions include:

- Expanding the class of drugs on the Preferred Drug List;

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- Auditing pharmacies to ensure compliance with the ‘favored nation’ policy;
- Increasing rebate collections;
- Allowing beneficiaries to use mail order for certain category of drugs; and
- Providing incentives to individuals who switch from brand to generic drugs.

Psychiatric Preferred Drug List

For SFY 2007, \$12 million was spent on anti psychotic medications in the RI Medicaid Program. This represented 18% of the total drug expenditure. Currently, this drug class is exempt from inclusion on the Preferred Drug List (PDL). The PDL was implemented in January 2007. In the first three quarters of 2007 the State has collected a total of \$1.3 million in supplemental rebates. Doctors prescribing less expensive but clinically effective medication achieved additional savings. The inclusion of the antipsychotic medications on the PDL can further contribute to a savings in the Medicaid under the demonstration. This transition can be accomplished without any disruption in medical care for the State’s Medicaid beneficiaries.

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Chapter Three: Caseloads and Program Funding

The State of Rhode Island has been a national leader in implementing innovative practices to provide a high quality and cost effective Medicaid program. As the smallest state in the union, Rhode Island is uniquely positioned to confront, head-on, the challenges that maintaining a successful and sustainable Medicaid program pose today. Through this proposal, Rhode Island is taking on this challenge and, addressing fundamental issues in Medicaid organization, financing and service delivery.

The Global Consumer Choice Compact provides Rhode Island with a new method for financing the Medicaid program – global budgeting – that provides the State with the opportunity to accomplish significant and lasting change. As noted in the discussion of the global budgeting concept, the State is committed to maintaining the funding for the Medicaid program at an amount commensurate with current levels. Rhode Island is also determined to, at a minimum, continuing coverage of mandatory populations and services.

The State is confident that it has both the fiscal discipline and policy ingenuity to transform RI Medicaid into a financially sustainable program that not only meets but anticipates the needs of Rhode Islanders into the future. State Medicaid officials look forward to working with CMS to further refine and finalize these arrangements. To achieve this transformation, Rhode Island proposes a unique state-federal partnership that restructures the program in two fundamental ways.

First, the State proposes to change the traditional financial model to one based on defined “global” aggregated allotments for the program as a whole through fixed federal and state financial commitments. Second, in return for the greater fiscal certainty global budgeting provides on the financing side, the State is seeking the flexibility – administrative freedom -- required to sustain a person-centered, opportunity driven, outcomes-based system of health care.

This chapter outlines the supporting financial arrangements for the Global Compact waiver, and our methodology for developing these financial terms. Rhode Island proposes that the demonstration operate for three years, with two subsequent years of optional renewals. The demonstration will begin in Federal Fiscal Year (FFY) 2009 (October 1, 2008).

A. SUPPORTING FINANCIAL ARRANGEMENTS FOR THE GLOBAL COMPACT

The proposed Global Compact waiver deviates from the traditional Medicaid financing approach in which the federal government matches state spending on an open-ended basis. Under the new financing structure outlined here, the federal commitment will not be open-ended; instead, the State will receive federal financial participation through a fixed allotment. The amount of this

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federal allotment will be based on projected Rhode Island Medicaid costs. Again, in accepting the terms of this “defined” global allotment, the State is seeking the flexibility necessary to reform the Medicaid program to ensure that every beneficiary has access to the right services, at the right time and in the right setting for decades to come. The State recognizes that it will be a challenge to achieve meaningful reform within the financial limits of a global budget, but is confident that it will succeed during the course of the demonstration.

The proposed demonstration will allow both the State and the federal government to predict the annual and lifetime Medicaid budget for this demonstration with increased certainty. More importantly, the global budget will establish the basis for the fiscal solvency and sustainability of the Medicaid program in Rhode Island. Key financial elements of this proposal are described below:

1. Timing

Rhode Island proposes to operate the demonstration for three years, with two subsequent years of optional renewals. The demonstration will begin in Federal Fiscal Year (FFY) 2009 (October 1, 2008).

The proposed waiver period is as follows:

Waiver Year 1	Oct.1, 2008 - Sept. 30, 2009
Waiver Year 2	Oct 1, 2009 – Sept. 30, 2010
Waiver Year 3	Oct 1, 2010 – Sept. 30, 2011
Waiver Year 4 (option year)	Oct.1, 2011 – Sept. 30, 2012
Waiver Year 5 (option year)	Oct.1, 2012 – Sept. 30, 2013

2. Fixed Federal Contribution

The State of Rhode will accept from the federal government an aggregated allotment on a regular basis over the course of the demonstration for all Medicaid services⁵. The federal government will protect the State through additional funding to cover any costs resulting from: (1) a national epidemic, state of emergency, or catastrophe that affects program funding; (2) a major and prolonged economic downturn; (3) unanticipated and extraordinary events outside of the State’s control that cause Medicaid costs to increase at a substantial rate above projected amounts; and

⁵ Administration costs, disproportionate share payments to hospitals, and payments to local education agencies are excluded from this allotment.

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(4) costs resulting from any new legal obligation resulting from federal or State court rulings interpreting applicable laws or regulations or from any changes in federal laws, regulations or policies that expand the State's financial obligations. Additionally, the State must remain eligible for any additional federal financial participation or funding that may become available to the states in the form of fiscal relief, or as an incentive/reward for policy or programmatic change (e.g. FMAP adjustments and/or including regular FFP adjustments as called for in existing statute) and federal legislation that provides fiscal relief to state Medicaid agencies related to SCHIP reauthorization and SCHIP redistributions. The State must also be held harmless with respect to changes in federal legislation that may require Medicaid to cover additional services, populations and/or coverage groups.

3. Maintenance of Effort

In Rhode Island, as in many other states, Medicaid has steadily consumed an increasing proportion of the state budget. In SFY 2007, Medicaid program costs – excluding administrative expenditures and disproportionate share and LEA payments -- represented approximately 23 percent of the overall general revenue budget. (As indicated in Chapter Two, this figure reaches nearly 25% if these other expenditures are factored in to the total.). Under this compact, the State will commit to maintenance of effort based on the percent of the State budget committed to the Medicaid program for the base year (SFY 2007). That is, for each year of the waiver period, Rhode Island commits to a minimum Medicaid expenditure based on a fixed percentage of the general revenue budget. The methodology for determining this dollar amount will be delineated as review of this waiver proposal moves forward.

4. State Flexibility

Under the proposed demonstration, the State will have the program flexibility to optimize program efficiency and effectiveness. The State commits to continued coverage of all mandatory Medicaid populations and mandatory services. In the event that total available federal and state funds within the Global Waiver are not sufficient to maintain all current populations and benefits, the State requires the flexibility to make some adjustments to eligibility and services covered based on fiscal limits. Alternatively, if there are savings realized within the waiver budget, the State is committed to reinvesting funds into the State's Medicaid or other state-administered health care programs, including support services that can have impact on health care costs (e.g. assisted living, meals on wheels, accessible housing), wellness and prevention initiatives.

5. Total Rhode Island Medicaid Forecasted Expenditures

The State's forecasts for the full five-year period are presented below. Table I provides projected expenditures for a waiver period FFY 2009 through 2013 based on historical trends in the base period. The total annual amount of projected expenditures for the program is based on

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all federally matched Medicaid services, at the current Federal match participation rate of 52.51 percent⁶. Adjustments are made to enrollment and PMPM forecasts from the five-year base period to recognize specified trend anomalies, as noted in Section C below.

Table 3.1: Total Rhode Island Medicaid Forecasted Expenditures

	FFY2007	Trend Rate	FFY08	FFY09	FFY10	FFY11	FFY12	FFY13	5 Yr Cap
Medicaid TOTAL									
Enrollment	180,968	2.3%	186,995	192,460	195,633	198,494	202,644	207,154	
PMPM	\$ 793	6.8%	\$ 840	\$ 894	\$ 958	\$ 1,028	\$ 1,100	\$ 1,175	
Total Expense (\$Mil)	\$ 1,721	9.2%	\$ 1,886	\$ 2,064	\$ 2,249	\$ 2,450	\$ 2,675	\$ 2,922	\$ 12,359

Note: Values for Waiver Year 1 are derived from the Base Year (July 1, 2006- June 30, 2007) trended forward to the Waiver Year (October 1, 2008-September 30, 2009).

As indicated in the table, Rhode Island forecasts total Medicaid expenditures over the waiver period at \$12,359 million, based on an average enrollment trend of 2.3% and an average PMPM trend of 6.8% per annum.

B. METHODOLOGY FOR TOTAL RHODE ISLAND MEDICAID FORECAST

Step 1: Develop a baseline of five-year historical experience

To project expenditures, Rhode Island first examined enrollment and expenditure experience for SFY 2002 through SFY 2007. SFY 2007 serves as the base year for forecasting expenditures for Waiver Years 1 through 5. Table II presents the year-by-year experience of the Rhode Island Medicaid program for the five-year trend historical period SFY 2002 through SFY 2007.

Table 3.2: Rhode Island's Historical Medicaid Expenditure and Eligibility Experience, SFY 2002-SFY2007

Medicaid Global												5 Year CAGR
	SFY02	SFY03	SFY04	SFY05	SFY06	SFY07	SFY03	SFY04	SFY05	SFY06	SFY07	
Expenses												
Grand Total	\$1,169,486,184	\$1,267,554,429	\$1,383,736,241	\$1,478,767,336	\$1,589,972,764	\$1,664,346,667	8.4%	9.2%	6.9%	7.5%	4.7%	7.3%
Avg Eligibles												
Grand Total	168,486	174,150	179,031	181,685	182,280	180,317	3.4%	2.8%	1.5%	0.3%	-1.1%	1.4%
PMPM												
Grand Total	\$578	\$607	\$644	\$678	\$727	\$769	4.9%	6.2%	5.3%	7.2%	5.8%	5.9%

⁶ Forecasts use the current rate. Federal fiscal relief may serve to modify this rate during the five-year period.

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As indicated in the table, the average number of people eligible for the Medicaid program in SFY 2007 was 180,317, which accounted for \$1,664,346,667. This represented a PMPM of \$769.

For Table 3.2 note that:

- ❖ Expenditure data consists of total fee-for-service based payments as well as all payments made to health plans for managed care. Service expenditures are recognized on an incurred (date of service), not a paid basis, adjusted for completion
- ❖ The expenditures exclude disproportionate share to hospital (DSH), payments to local education agencies (LEAs), and administration costs.
- ❖ Adjustments to experience are made to reflect the prescription drug expenditures that were assumed by the Federal government as part of the Medicare Part D program. That is, expenditures made for Medicare covered prescriptions for dually-eligible individuals are removed from all years. This provides a more accurate basis for identifying historical trends applicable to the current program and for forecasting trends during the waiver period.
- ❖ Adjustment was made to include the experience of population groups that will no longer be eligible for federal matching through SCHIP and to recognize the current SCHIP allotment level for Rhode Island (\$13,957,989 for FFY 2008). Two population groups that have historically been eligible for coverage under SCHIP will no longer be claimable through SCHIP⁷. Expenditures for these groups will be covered through Medicaid and related expenditures are included throughout the period to more accurately capture the historical experience applicable to the program going forward.
- ❖ Expenditures were captured and analyzed by three subgroups: (1) Dually Eligible (Medicaid and Medicare) Adults ages 21 and older; (2) Non-dually Eligible Adults (Medicaid only) ages 21 and older; and (3) All Children and Families.

Step 2: Translate historical experience into baseline projections

Step two in this process was to translate the historical experience into baseline projections – that is, based on the experience shown in step 1 above, what are the projected Rhode Island Medicaid enrollment and expenditures?

As indicated in Table 3.3, baseline projections, based solely on historical experience, would suggest a five-year capitation of \$11,560 million, with enrollment trends of 1.4% and PMPM trends of 6.1%.

⁷ These are: (1) Custodial parents or caretaker relatives of Medicaid/SCHIP children with above 100% FPL to 185% FPL and (2) Pregnant women, including those 60-days postpartum above 185% FPL to 250% FPL.

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Table 3.3: Baseline Projected Rhode Island Medicaid Expenditures, FFY 2008-2013

	FFY2007	Trend Rate	FFY08	FFY09	FFY10	FFY11	FFY12	FFY13	5 Yr Cap
Medicaid TOTAL									
Enrollment	180,968	1.4%	183,443	185,953	188,497	191,078	193,694	196,346	
PMPM	\$ 793	6.1%	\$ 840	\$ 891	\$ 945	\$ 1,003	\$ 1,064	\$ 1,130	
Total Expense (\$Mil)	\$ 1,721	7.5%	\$ 1,849	\$ 1,988	\$ 2,137	\$ 2,299	\$ 2,474	\$ 2,663	\$ 11,560

- ❖ Projections were developed for three core subpopulation groups within Medicaid. These are: (1) Dually Eligible (Medicaid and Medicare) Adults ages 21 and older; (2) Non-dually Eligible Adults (Medicaid only) ages 21 and older; and (3) Children and Families⁸.
- ❖ Adjustment for expenditures not claimed: An adjustment of \$26,189,010 was made to the SFY07 base in expenditures for which State claiming authority is available but which the state did not claim. Examples of these costs include inpatient and outpatient hospital costs, inpatient hospitalizations for inmates of public institutions⁹ and eligible but unreported costs under the 1915(c) MR/DD Waiver.

Step 3: Adjust Projection for Anomalies

The baseline projections were then adjusted for data anomalies. Table 3.4 provides the projected enrollment, PMPM and total expenditures for a five-year waiver period (Base years FFY 2009, 2010, 2011; and option years 2012 and 2013), after adjustments for anomalies.

These adjustments result in projected Rhode Island expenditures of \$12,359 million over the waiver period, PMPM trends of 6.8% and enrollment trends of 2.3% (as compared to baseline trends of 6.1% and 1.4% respectively).

Table 3.4: Adjusted Rhode Island Medicaid Expenditures, FFY 2008-2013

	FFY2007	Trend Rate	FFY08	FFY09	FFY10	FFY11	FFY12	FFY13	5 Yr Cap
Medicaid TOTAL									
Enrollment	180,968	2.3%	186,995	192,460	195,633	198,494	202,644	207,154	
PMPM	\$ 793	6.8%	\$ 840	\$ 894	\$ 958	\$ 1,028	\$ 1,100	\$ 1,175	
Total Expense (\$Mil)	\$ 1,721	9.2%	\$ 1,886	\$ 2,064	\$ 2,249	\$ 2,450	\$ 2,675	\$ 2,922	\$ 12,359

⁸ Forecasting Medicaid expenditure based on the specific contributions to the cost and enrollment experience of these subgroups yields a slightly higher aggregate trend than is seen in Table 3.2.

⁹ Please see CFR 435.1008 and 435.1009.

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Adjustments to baseline forecasts were made in four areas:

❖ **Population Shifts: Aging Population**

An adjustment was made to recognize that an aging population within Rhode Island is projected to result in an increased number of eligibles over age 65 during the waiver period. As such, Medicaid eligibles for the ABD population were projected based on Medicaid's historical share of Rhode Island's population. This projected share of the population was then applied to census projections for the waiver period¹⁰.

❖ **2006-7 Enrollment Trend Anomalies**

Five year trends in caseload growth during the 2002-2007 period for children and families and for dually eligible adults are affected by two period-specific, non-recurring events. These are:

(1) Caseload declines of children and families associated with DRA related citizenship requirements. Absolute changes in caseload levels reflect the impact of these changes but distort the overall trend. For this analysis, the caseload trend is based on the historical 2002-2006 experience.

(2) Caseload decline among dually eligible persons. The introduction of Medicare Part D prescription drug coverage is associated with an enrollment decline in 2006 and 2007, as certain persons who previously enrolled in Medicaid primarily to access the Medicaid pharmacy benefit no longer did so. Adjustment is made by forecasting the dually eligible population based on the experience for the 2002-2006 periods.

❖ **Adjustment for Historical Data/Anomaly Year Cost**

The cost trend in 2002 represents an anomaly from an otherwise consistent five-year trend series. Given that this was the oldest year of historical data and the State does not believe it is representative of historical experience, the PMPM cost experience is based on the 2003-07 data.

❖ **Adjustment for increased unemployment.**

The Rhode Island unemployment rate remained relatively stable, and below national figures for the period 2002 through 2005. However, this is expected to change, as Rhode Island's unemployment levels are expected to increase substantially, to above national levels throughout the waiver period¹¹. The projections are therefore adjusted for the expected increase in Medicaid eligible Rhode Islanders due to rising unemployment during the waiver period.

¹⁰ Source: US Census Bureau population statistics by age group (21-64 and 65+)

¹¹ Source: Moody's Forecast of unemployment rates, nationally and for Rhode Island. The unemployment adjustment is based on a Kaiser/John Hollohan model, estimating impact of rising unemployment on Medicaid enrollment trends. This model provides an estimated number of additional enrollees due to each 1% increase in unemployment rates. Because unemployment is projected to increase, then decreases over the waiver period, the adjustment is added "on top of trend" and is therefore not reflected in the projected trend.

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C. OTHER ISSUES

1. Expenditures Incurred but not yet reported (IBNR)

The proposed waiver period begins on October 1, 2008. While the waiver is in effect there will be outstanding claims from periods prior to the start of the demonstration. The State recommends that these pre-waiver expenses continue to be paid separately from the waiver allotments using the current process.

Also there will be Medicaid payables resulting from services incurred but not paid as of September 30, the Federal Government's fiscal year-end. This amount is the net of unreported expenses incurred by the state less amounts owed to the state for overstated claims and drug rebates. The Centers for Medicare & Medicaid Services (CMS) prepared its fiscal year (FY) 2007 Annual Financial Report as required by the Public Law 103-356, (the Government Management Reform Act of 1994), section 3515. The CMS accrued an estimate of 1) an accounts payable for the services rendered by Medicaid providers as of the end of the fiscal year, which have not yet been reported on the Quarterly Statement of Medicaid Expenditures, Form CMS-64, and 2) an accounts receivable for all amounts due to the states from various sources, excluding the Federal Government. The CMS recorded a net payable estimate of \$106.6 million for Rhode Island in FY 2007.

2. RItE Care 1115 Savings

As noted above, the proposed Global Compact demonstration will encompass the existing RItE Care Section 1115(a) waiver. The RItE Care waiver has generated Medicaid program savings to both the State and the federal government. The State feels strongly that its cost-savings efforts under RItE Care should be incorporated into the financing of the Global Compact. The State requests that the savings in the RItE Care demonstration "pool" of "Without Waiver" funds be recognized and added to the fixed Federal contribution.

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Chapter Four: Eligibility Under the Global Compact Waiver

The central purpose of the Global Compact waiver is to transform the RI Medicaid program to make it not only more responsive and more cost-effective, but also to ensure its continued viability for generations to come. As such, the State is proposing to implement relatively few changes in the number of Title XIX eligible mandatory and optional coverage groups during the demonstration. Additionally, the State plans to maintain all current Section 1115 (a) and 1915 waiver eligible coverage groups under the Global Compact. By contrast, the State is proposing to use the flexibility under the Global Compact to revamp significantly certain eligibility criteria and/or requirements during the demonstration.

The section below describes current Medicaid coverage groups and the modest changes proposed during implementation of the demonstration. A description of the planned reforms in eligibility requirements and processes associated with each component of the waiver follows.

A. MEDICAID COVERAGE GROUPS – Current and Under the Global Compact

The Rhode Island Medicaid program includes many different categories of eligibility based on one or more characteristic, nearly 80 percent of which are optional under Title XIX. Most of these optional groups consist of children and their parents with income above the levels established in Title XIX for mandatory coverage that became eligible for Medicaid through the RIte Care waiver during a series of expansions in the mid to late 1990s. As indicated in Chapter One, more recently, the trend has been to extend coverage via Section 1915 (c) waivers to beneficiaries residing in the community who might otherwise only be eligible for full Medicaid State Plan services if they were cared for in the institutional setting.

1. Coverage Groups Today

Figure 4.1 shows the eligibility pathways for the four major Medicaid populations as they exist today. A brief description of eligibility by population follows.

Figure 4.1: RI Medicaid Populations and Eligibility Pathways	
Medicaid Population	Eligibility Pathways
Children and families in managed care (children under 19 and their parents)	FIP/TANF; Section 1115(a) Waiver eligible; SCHIP; Certain poverty level children who are not eligible for TANF; 1931(e) expansion parents
Children with special health care needs (as an eligibility factor)[under age 22]	Children who are: Blind and disabled SSI recipients; Katie Beckett eligible (eligible up to 19 th birthday);

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Figure 4.1: RI Medicaid Populations and Eligibility Pathways

Medicaid Population	Eligibility Pathways
	DCYF substitute care; DCYF Independent foster care youths under the Chafee option; and DCYF subsidized adoption
Adults with disabilities (age 22-64)	Blind and disabled recipients; Medically needy; Blind & disabled persons at or below the poverty level, including persons with developmental disabilities; Long-term care eligible
Aged (age 65 and over)	Aged, blind and disabled SSI recipients; Medically needy; Persons at or below the poverty level; Long-term care eligible

a. Children and Families

As noted earlier, children and families in RIt Care and RIt Share represent the largest Medicaid population. When making the request for the RIt Care waiver, the State indicated to federal officials that its objective was to demonstrate that providing health coverage through a managed coordinated delivery system would improve service access, quality and outcomes and, at the same time, provide sufficient cost savings to expand Medicaid eligibility and maintain budget neutrality.¹²

RIt Care largely succeeded in achieving this end. Today, the population of children and families eligible under the RIt Care program includes uninsured and underinsured individuals in the following groups:

- ❖ TANF and TANF-related families (Section 1931), poverty level children and pregnant women eligible for Medicaid under Rhode Island's existing State Plan;
- ❖ Children who are covered under 1115 demonstration authority who could be made eligible through a State Plan amendment under section 1902(r)(2) and related provisions or SCHIP – children up to age 19 in households with incomes up to 250 percent of the FPL who are uninsured;

¹² Materials related to the RI RIt Care waiver, including the initial requests and various amendments is maintained on the CMS website at:
<http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp?filtertype=dual&datefilterinterval=&filtertype=data&datafiltertype=2&datafiltervalue=Rhode%20Island&keyword=&intNumPerPage=10&cmdFilterList=Show%2bItems>

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- ❖ Parents and relative caretakers with income up to 175 percent FPL; and pregnant women with income from 185 to 250 percent of the FPL who are covered under 1115 demonstration authority who could be made eligible through a State Plan amendment under section 1931 and related provisions; and
- ❖ Women who lose Medicaid eligibility 60 days post partum and are eligible for extended family planning services under 1115 waiver authority.

Families in these coverage groups with access to employer-sponsored insurance (ESI) that meets the State's cost-effective test under Section 1906 of Title XIX are enrolled in RI Medicaid's premium assistance program, RIte Share.

Upon federal approval of the Global Compact, the RIte Care Section 1115(a) demonstration will be absorbed into the new waiver. As indicated in the next section, one new demonstration coverage group will be added to this population under the Global compact waiver.

b. Children With Special Health Care Needs

Children with special health care needs (CSHCN) eligible for Medicaid are primarily members of mandatory coverage groups under Title XIX. The exceptions are the optional coverage groups composed of children eligible under the Katie Beckett and non-IV E adoption assistance provisions of the Medicaid law as well as those older than eighteen years of age and/or with income above the mandatory levels set for children in poverty. The CSHCN population includes the following groups of individuals eligible under the designated Section of Title XIX for State Plan services:

- ❖ Children under age 18 in State custody – i.e., substitute care – either in a group home or individual placement eligible under Section 1902 (10) (A)(i)(I);
- ❖ Children under age 21 receiving Supplemental Security Income (SSI) due to disability eligible under Section 1902 (10)(A)(i)(II);
- ❖ Children 19 and under eligible under Section 1902(A)(ii) known as the “Katie Beckett” provision;
- ❖ Independent foster care adolescents, between the ages of 18 and 21, eligible for Medicaid under Section 1902(a)(10)(A)(ii)(XVII); and
- ❖ Children under 21 whose families receive adoption assistance under Section 1902 (A)(ii)(IV).

Though the proposed Global Compact makes significant changes in the services and delivery system for the CSHCN populations – e.g., mandatory enrollment in managed care for all

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beneficiaries and transition of beneficiaries from residential care facilities to home-community based services, only one demonstration coverage group will be added.

c. Adults With Disabilities

Adults with disabilities who are eligible for Medicaid are generally between the ages of 19 and 64. Members of this population fall into one of three groups as either categorically or medically needy under Section 1902 of Title XIX:

- ❖ Adults with developmental disabilities and mental retardation;
- ❖ Non-elderly adults who are physically disabled and/or chronically ill; and
- ❖ Individuals who are severely and persistently mentally ill.

A special eligibility group for working adults with disabilities was established in January 2006. Called the Sherlock Plan, members of this population may have up to 250 percent of FPL in countable income,¹³ and up to \$10,000 in countable assets. Individuals eligible for Medicaid in this coverage group pay as their monthly premium all unearned income (such as Social Security income) over 100 percent of the poverty level and an amount equal to the RItE Care and RItE Share premiums on earned income over the Medically Needy Income Level. The State plans to examine these premiums and make changes accordingly.

Adults with disabilities who require long-term care services may qualify for Medicaid eligibility with income up to 300 percent of the federal Supplemental Security Income (SSI) benefit level. Beneficiaries have to contribute to the cost of their care all income over \$55 when residing in institutional settings. Long-term care applicants who wish to reside in the community may also qualify for Medicaid coverage when they have income above the 300 percent federal benefit level, but only if they pay toward the cost of their care all income above the Medically Needy Income Limit (MNIL).

As indicated earlier, the State currently extends eligibility for home and community-based long-term care services to certain adults with disability under Section 1915 (c) of Title XIX using this same income standard. For those beneficiaries living in a community-based setting, the cost share is any income above the poverty level. Medicaid currently pays for all room and board costs in institutional settings, but not in the community.

d. Elderly Adults

Elderly adults eligible for Medicaid must be 65 years of age and meet the State's income and assets tests. As is the case for adults with disabilities, the elderly population also includes persons 65 and over elders who qualify as "medically needy" under Section 1902 of Title XIX.

¹³ Countable income includes all unearned income such as pensions or social security and one half of all earned income from employment after the first \$65 is deducted.

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In terms of resources or assets, individuals with income at or below the federal poverty level may have up to \$4,000 in countable assets. Those with income above the poverty level can have no more than \$2,000 in countable assets.

The majority of Medicaid beneficiaries receiving long-term care State Plan and Section 1915(c) waiver home and community-based services are members of the elderly population. The income standard for long-term care for elders is the same as for adults with disabilities – i.e., up to 300 percent of the federal SSI benefit level. The State plans to add within the elderly population under the Global Compact waiver, a new demonstration coverage group as noted below.

2. Proposed Changes to Coverage Groups Under the Global Compact Waiver Demonstration

To achieve the goals of the Global Compact Waiver identified under the three main components – rebalancing the long term care system, mandatory care management and “ fair share payments and purchasing – the State proposes to establish several new coverage groups. Figure 4.2 summarizes these groups. A brief description and explanation for the planned changes in eligibility follows.

Figure 4.2: New Demonstration Coverage Groups

Medicaid Population	Demonstration Coverage Group	Title XIX Authority
Children and families in managed care (children under 19 and their parents)	Parents Pursuing Behavioral Health Treatment with of Children Temporarily in State Custody	Section 1902(10)(A)
Children with special health care needs (as an eligibility factor) who are 21 and under	Children Who Would Otherwise be Voluntarily Placed in State Custody	Section 1915(c)
Adults with disabilities (age 22-64)	No changes	NA
Elders (age 65 and over)	Elders at risk for LTC with income at or below 200% of the FPL who are in need of home and community based services	Section 1902(r)(2)

a. Certain Parents of Children Temporarily in State Custody

The population of children and families enrolled in RItE Care may lose their health coverage for a variety of reasons, including an increase in income, availability of employer-sponsored insurance, failure to complete re-certification or because the family’s circumstances change.

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One change of circumstances that currently results in a loss of eligibility is when a parent who is enrolled in RItE Care loses custody of a child temporarily – placed in “substitute care” because the child is placed in the custody of the State’s child welfare agency, the RI Department of Children, Youth and Families (DCYF).

Although children are placed in substitute care for a broad range of reasons, in a small number of cases, the child is removed from the home because a parent is abusing either legal or illicit substances or is experiencing serious behavioral health issues. Data from the DCYF show that, on average, between 200 and 250 parents enrolled in RItE Care lose coverage for these reasons.

The State is concerned that the loss of Medicaid eligibility is preventing a significant number of these parents from obtaining the Medicaid covered treatment services they need to overcome the conditions that led to removal of their child(ren). Severing access to Medicaid for parents in this situation not only is inconsistent with the principles of reform focusing on optimizing health and achieving wellness, but also with the State’s longstanding commitment to build strong healthy families. Indeed, the DCYF indicates that without access to the right treatment services, at the right time and in the right setting, the prospects for family reunification diminish and the likelihood that temporary placement in substitute care will become permanent increases significantly over time.

The State proposes to use the flexibility under the waiver to continue RItE Care coverage for up to 12 months for uninsured parents/caretaker relatives who would otherwise be Medicaid eligible under Section 1902 (10)(A) were it not for the temporary placement of a dependent child in substitute care. For the purposes of determining/maintaining Medicaid eligibility under such circumstances, the child will continued to be treated as a member of the application unit of the household, but only when the following conditions are met:

- ❖ The parent/caretaker enters, continues and/or completes a State approved treatment program;
- ❖ The parent/caretaker relative adheres to established treatment protocols (e.g., no substance abuse, medication compliance, attending therapy or 12-step meetings, etc); and
- ❖ There is a continuing expectation by DCYF and the court that family reunification is possible.

Individuals eligible under these conditions will be subject to all applicable RItE Care program requirements, including cost-sharing. As such, the State expects the actual number of beneficiaries qualified to continue coverage under this provision will be somewhat less than the total pool of potentially eligible parents/caretaker relatives.

Note, as beneficiaries qualifying for continuing coverage in this group may include some individuals after their release from prison or jail, oversight will be done in close collaboration

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with DCYF and the Family and Juvenile Drug Court,¹⁴ which will notify RI Medicaid if the terms for continuing eligibility are not being met. If this is the case, the parent will be disenrolled from RIte Care.

The State expects that the costs for maintaining coverage for parents/caretaker relatives in this group may be higher than for RIte Care enrollees of a similar age and income due to utilization of substance abuse treatment and/or mental health services. However, as the Medicaid costs for covering and maintaining children in substitute care tend to increase substantially over time, the State expects that this proposed expansion will yield savings in the future.

Also, the State views the continuation of coverage for parents/caretakers under these circumstances to be an important adjunct to the three central components of the Global Compact Waiver – rebalancing the system (e.g., family unification keeps children out of high cost institutional and residential care venues), mandatory care management (e.g., parents enrolled in RIte Care will have access to the full range of medical/behavioral health care management services) and Fair Share (e.g., parents will be responsible and accountable for the Medicaid services they utilize and the State will be able to use its purchasing power to encourage substance abuse and behavioral health providers to focus on building health and resilient families.)

b. Children Voluntarily Placed in State Custody

At any given point in time, there are approximately 100 children who have been voluntarily placed in State custody by their parents because they otherwise would not qualify for the Medicaid covered services they need on the basis of income or disability. These children typically need an array of institutional level medical and behavioral health services that their parents cannot afford or obtain through commercial insurance. As such services are covered for the CSHCN population in substitute care under the provisions of Title XIX related to IV-E eligibility, parents voluntarily make their children wards of the State to ensure they have access to needed care.

As a practical matter, once a child is voluntarily placed in substitute care, home and community-based services are not an option, even if available and appropriate. Most children in this group are placed in high cost service venues, usually a residential facility or psychiatric hospital. Often these venues provide a more intensive level of services than the child needs. Moreover, once the child is out of the home and placed in these settings, the ability of parents to participate and control the course of treatment their child receives is diminished.

The State recognizes that for some children with serious emotional disturbances, developmental disabilities and/or other behavioral health needs, the right care may only be available in a hospital or residential facility setting. However, the State agencies that provide services to these children are confident that many can safely and securely obtain the services they need at-home or

¹⁴ The Drug Court is the product of a collaboration of the offices of the Family Court, Attorney General, Public Defender, DCYF, Department of Human Services, other State agencies, and General Assembly as well as members of business, minority, and community groups.

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in less restrictive community based settings. It is this premise that underlies the State's proposal to divert/transition children residing in high cost venues when appropriate and to establish networks of providers that deliver community-based wraparound services that meet the needs of the children and their families.

Accordingly, the State proposes to establish eligibility for home and community-based services for a limited number of children who have been or would be voluntarily placed in State custody by their parents in order to obtain Medicaid covered services. For the purposes of this special home and community-based group, RI Medicaid will establish a special family income level based on legislation enacted for this purpose. The DCYF in collaboration with DHS will be responsible for determining the relevant eligibility criteria for families with income at or below this level.

Children eligible in the special coverage group will be enrolled in a Rite Care managed care plan and have access to all the home and community-based services deemed appropriate for their level of care needs as determined by the ASO in conjunction with the DCYF.

c. Elders At Risk for Long-Term Care

Under current income eligibility guidelines, many elders at risk for an institutional level of care do not qualify for Medicaid due to excess income and/or resources. Most members of this group, even those who have access to some form of health insurance, will not be able to afford or obtain coverage for the at-home services and supports they need to maintain their health and independence. Eventually, many of these elders will become Medicaid beneficiaries, but only after their health has deteriorated to the point that they require an extensive array of high cost institutional level services if not immediate placement in a nursing home.

The State proposes to use the flexibility provided under the waiver to establish a new Medicaid coverage group for elders currently receiving a limited array of community based support services through the RI Department of Elderly Affairs, Community Living Options Co-pay program. Elders in this program with income up to 200 percent of the FPL who qualify on the basis of need will be provided with access to a limited array of home-based supports to optimize their health and reduce the risk for institutional placement. These are generally individuals who have been determined to have a "high" service need under the State's new matrix for assessing level of care explained in Chapter Two. This program is only open to individuals who have their medical coverage through another third party such as the Federal Medicare since home and community based services are the only services covered for this group. The State anticipates that approximately 2600 elders will qualify for this new Medicaid coverage group.

Addressing the service needs of elders before they require institutional care is not only cost-effective, but also an important mechanism for ensuring access to the right services, at the right time, and in the right setting. However, due to resource constraints in the first years of the demonstration, the number of elders eligible for coverage in this eligibility group will be limited, either by establishing a cap or through appropriations, as will the scope of home and community-based services they are qualified to receive.

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B. CHANGES IN ELIGIBILITY REQUIREMENTS AND PROCESSES

Besides streamlining the eligibility and intake process, Rhode Island is considering making changes to a number of policies pertaining to eligibility and financial requirements. The eligibility and financial requirements for Medicaid long-term care and community support services will be modified to reduce the bias toward institutional placements and broaden access. Each of the changes proposed is outlined below by applicable component of the Global Compact waiver.

- ❖ Allowing for an income disregard for living expenses. The current allowance of \$758 is not sufficient to cover the actual living expenses of beneficiaries who choose to obtain services in the community. The enhanced disregard will only be available to individuals in need of a high level of care. In addition to the \$758, the enhanced disregard will include an additional \$100 for electric utilities, \$100 for heat, and \$200 for rent/mortgage payment, thus allowing qualified beneficiaries to keep about \$1158 a month;
- ❖ Implementing presumptive eligibility so that individuals can receive needed home and community based services immediately while financial eligibility is being determined;
- ❖ Enabling families of Medicaid eligibles receiving or at risk of requiring long-term care to access the services and supports required to transition to/remain in the community;
- ❖ Implementing a Long-Term Care Partnership Program;
- ❖ Offering individuals who purchase reverse mortgages the same set of incentives available to those participating in the Long-Term Care Partnership Program;
- ❖ Enabling the State to treat short term stays in Skilled Nursing Facilities (SNF) services as a community Medicaid benefit – i.e., apply the Medicare financial eligibility requirements. Currently long-term care eligibility rules are applied to individuals in need of SNF services. The State would like to eliminate the necessity of applying for LTC and have individuals in need of these services apply as community medical assistance beneficiaries; and
- ❖ Extending eligibility for Medicaid coverage of certain costs associated with transitioning beneficiaries from high cost institutional and residential venues to less restrictive settings in the community.

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Chapter Five: Global Compact Services

Under the Global Compact, the State intends to initially maintain all existing State Plan services, RIte Care services, and services approved under the current 1915(c) Home and Community-based Waivers and its 1915 (b) dental benefit waiver. The change that will occur under the Waiver will be the ability of the State to develop service packages that are better aligned with the needs of Medicaid beneficiaries. For example, in the area of primary and acute care, the State will seek to provide benefit packages that more closely match those offered in the private market. In the area of long-term care, the State will develop alternative or targeted services for beneficiaries before they meet an institutional level of care in order to divert, prevent or delay placement in high cost institutional and residential settings much more effectively than is allowed under current regulations.

A. DESCRIPTIVE SUMMARY OF SERVICES

Under this Waiver, the State seeks the ability to vary the amount, duration, and scope of services offered to beneficiaries regardless of eligibility category.

1. Nursing Facility Services, Long-term Care Hospital Services, and Intermediate Care Facility Services

The State recognizes that the services provided in nursing facilities, long-term care hospitals, and intermediate care facilities are vital services and must be made available to Medicaid beneficiaries. As stated throughout this proposal, however, the entitlement to services provided in these settings has resulted in an over-reliance on them. One of the integral components of the Global Compact, re-balancing long-term care, is based on the understanding that many beneficiaries would prefer to live at home and in the community for as long as is possible. Through the development of a three-tier level-of-care determination, the State seeks to change the nature of the Medicaid entitlement so that community-based care is as easy as or even easier to access than institutional care.

2. Home and Community Based Services

To ensure that community-based care is easily accessible, the State seeks to expand home and community-based services in two ways: the State will add to the list of available services and will expand who can access them.

Currently, the State has nine existing 1915(c) Waivers. Each waiver provides slightly different home and community based services. The Global Compact will consolidate services currently provided under the nine 1915(c) waivers and group them as core or preventive services. As noted in Chapter Two, the core and preventive services are:

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Core Services		Preventive Services
Personal Care Services	Service Coordination	Homemaker Services
Home Health Services	Assisted Living	Minor Home Modifications
Home Modifications	Medication Management	Respite
Companion Services	Meals on Wheels	Rehabilitative Therapy Evaluations
Supportive Employment	Adult Day Care	Home-Based Treatment Services
Personal Emergency	Shared Living	
Response Systems	Assistive Devices	
Adult Day Programs	Family Support	
Transition Services	Behavior Management	
	Case Management	

The Assessment and Coordination Organization will determine access to the above services with the active participation of the Medicaid beneficiary who has been assessed to need long-term care services.

3. Services to Maintain Children and Adolescents in the Community

To transition or divert children and adolescents from long-term residential placements to home-based and less restrictive community settings, the State will actively pursue the implementation of the National Wraparound Initiative (Wraparound). Wraparound is a team-based planning process intended to provide individualized, coordinated, family-driven care to meet the complex needs of children who are involved with several child- and family-serving systems (e.g. mental health, child welfare, juvenile justice, special education), who are at risk of placement in institutional settings, and/or who experience emotional, behavioral, or mental health difficulties. The wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then work with family members and child(ren) to implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as all parties deem necessary. The team continues its work until members reach a consensus that a formal wraparound process is no longer needed.

The broad range of services available to families and children under the Wraparound process include services encompassed under the current Medicaid State Plan, the home and community-based services listed above, and a small amount of State-only flexible funds that allow the family to individualize care to access unique services that are not covered by Medicaid under the Global Compact waiver.

4. Behavioral Health Services

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Rhode Island recognizes that in order to achieve the goals of the Waiver, access to a comprehensive array of covered behavioral health services that will assist, support, and encourage each eligible person to achieve and maintain the highest possible level of recovery, physical health, and self-sufficiency is essential. Behavioral health services require special attention due to the impact that untreated mental illness and substance abuse can have on a person's physical health and well being, a child's safety and permanent living situation, and the family's healthy environment.

The President's New Freedom Commission on Mental Health's final report, *Achieving the Promise: Transforming Mental Health Care in America*, states: "Understanding that mental health is essential to overall health is fundamental for establishing a health system that treats mental illnesses with the same urgency as it treats physical illnesses." The report goes on to say, "research demonstrates that mental health is key to overall physical health." The State recognizes that access to behavioral health services will be instrumental in achieving the goals of rebalancing long-term care and improving the management of acute care.

5. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)

The State intends to maintain the EPSDT policy.

6. Rite Care Services and Rite Smiles Services

The State intends to subsume the Rite Care and Rite Smiles programs within this demonstration. The State will continue to operate the Rite Share programs to maximize third-party health insurance to ensure Medicaid remains the payer of last resort. The State will also continue to offer Extended Family Planning services for post-partum women who meet certain income guidelines and are no longer eligible for Rite Care/Rite Share.

B. SERVICES UNDER THE WAIVER

In general, there will be two main differences between the services available under the current Rhode Island Medicaid Program and the services that will be available under the Global Compact: the number of services available and the way current and prospective beneficiaries access them. The State intends to make more services available. As noted above, home and community-based services will be more accessible. The State also seeks the flexibility to add any service listed in Section 1905 of the Social Security Act (SSA) but not included in the current Rhode Island Medicaid State Plan to services provided under the Global Compact.

For example, Rhode Island's current State Plan does not include chiropractic services. Under the flexibility of the Global Compact, the State will seek the ability to provide these services without prior approval from the federal government. The requested flexibility will also allow the State to offer these services in a targeted manner. Again, the State may choose to provide chiropractic services only when certain acute conditions exist and there is a potential for rehabilitation.

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The second major difference will be in the way Medicaid eligible beneficiaries access Global Compact services. The State intends to fully support and pursue the concept of self-directed care for as many beneficiaries and services as may be appropriate. While self-directed care is not a service itself, but an approach to accessing services, it does change the nature of services. One of the areas in which the State is seeking flexibility is the ability to implement self-directed care without requiring prior approval from the federal government. As a case in point, the State intends to enable beneficiaries and their families to take advantage of self-directed Personal Assistance Services. The State will comply with the program requirements listed in Section 1915(j) of the SSA, but will not seek federal approval prior to implementation. Although the RI Medicaid seeks the ability to add services that are already allowable under the State Plan, the State acknowledges that any service that is not a Section 1905 service, HCBS waiver service, current RIte Care service or not authorized by this waiver would require additional oversight and approval from the federal government.

The flexibility to determine the most appropriate service package for beneficiaries is a crucial element in the State's ability to design a Medicaid program that supports the Guiding Principles of Consumer Empowerment and Choice; Personal Responsibility; Freedom; Community-based care solutions; and Prevention, Wellness and Independence.

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Chapter Six: Quality Monitoring and Management

Quality assurance is defined by CMS (Evaluating Demonstrations: A Technical Guide for States, CMS, March 2007) as the organizational structure and process for retrospectively and concurrently reviewing and assessing the appropriateness, sufficiency, and quality of healthcare services provided to Medicaid enrollees. By contrast, quality improvement is defined by CMS as the development and implementation of a prospective strategy for improving and strengthening the quality of health care provided to Medicaid enrollees.

This Chapter describes the quality assurance and improvement structure, process, and system components necessary to achieve value in the Medicaid program for beneficiaries and taxpayers under the Global Compact waiver. The quality strategies described below are built upon the CMS Quality Framework elements of *discovery*, *remediation*, and *improvement* as well as CMS Waiver Assurances. The Quality Monitoring and Management Plan will incorporate the planned activities outlined in Rhode Island's Real Choice Systems Transformation grant, under which Rhode Island is making systematic changes to long-term care assessment processes and payment to providers in order to improve access to home and community based long-term care services that meet state standards for quality.

The design of the Quality Plan for the waiver, in keeping with the principles of Medicaid reform outlined in previous chapters will involve participants in defining the quality of services and supports.

A. QUALITY ASSURANCE AND IMPROVEMENT STRUCTURE

In implementing a quality assurance and improvement structure for the proposed waiver, the State is proposing to base the structure on the following criteria which align with the overall guiding principles of the waiver:

1. Have consistent approach. The State will design and implement a consistent and coordinated quality framework and interagency approach across all waiver populations while maintaining accountability and responsibility for quality monitoring, management, remediation and improvement within specific departments;
2. Be data-driven. The State will design and implement a legally sound, shared, consistent, coordinated framework and method for quality-related data collection that results in user-friendly access to data, analysis of key trends, reporting to state and federal officials, and dissemination of clear and concise information across all agencies with responsibility for Medicaid populations and to public stakeholders;
3. Ensure quality improvement systems in place at the delivery system level. In its contracts with providers, the State will hold providers and health plans responsible and accountable for quality assurance and quality improvement activities within their

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own settings. The state's role then becomes one of a purchaser that establishes key performance indicators with oversight and monitoring of quality assurance and improvement processes and activities conducted by its service providers, including discovery, remediation, and improvement.

4. Make quality of care information transparent. The State will ensure the availability of provider and Health Plan quality information so that consumers may make an informed choice of provider and health plan based on quality performance.

5. Pay for Performance. The State will align Medicaid purchasing and payment methods to reward effective quality assurance and quality improvement systems developed and implemented at the provider or health plan level that demonstrate desired outcomes.

1. Consistent quality framework and interagency approach

The State of Rhode Island is proposing to implement strategies to integrate quality measures across various state agencies that are responsible for specific populations within Medicaid programs who will be served through this new waiver. The intent is to enhance quality assurance and improvement system components and individual quality of life outcomes for waiver beneficiaries and their families.

The State will design and implement a consistent, coordinated framework, policies, and reporting mechanisms for quality assurance and improvement to cover the full scope of the waiver. This framework will allow for differentiation of quality strategies and procedures across departments and populations to account for the variations and other statutory requirements, as appropriate. This will require the development of an infrastructure for communication and coordination among state agencies on the quality assurance and improvement systems and performance.

A Waiver Quality Director will be primarily responsible for coordinating with all state agencies to assure the development and implementation of all aspects of the quality assurance and improvement plan for the waiver. The Waiver Quality Director will establish an interdepartmental Quality Team made up of a Quality Director from each state agency with responsibility for a Medicaid enrolled population and/or with data or responsibility for monitoring providers and health plans that are responsible for providing services within a quality framework. The Quality Team will meet routinely and will determine the participation needed from other appropriate entities such as the Department of Health licensing and regulation divisions, public and private quality assurance organizations, representatives of various consumer, advocacy, public policy and stakeholder groups.

The Waiver Quality Director and Quality Team members will develop and implement a consistent, coordinated quality framework and policies for the waiver, including an interagency coordination and communication strategy. The Waiver Quality Director and Team will develop a comprehensive Quality Plan for the waiver for CMS review and approval. The Waiver Quality

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Director and Quality Team will be responsible for ensuring that the Quality Plan is implemented across all agencies, and will monitor the implementation and results on an ongoing basis. The Waiver Quality Director will submit routine reports to the EOHHS and Department Directors on the status of implementation of the Quality Plan, including information from the “discovery” component of the plan, remediation actions taken, and improvement results. The Waiver Quality Director will be responsible for an annual waiver quality report for public dissemination.

2. Data-driven framework and method for quality-related data collection, access, analysis, reporting, use and dissemination

In order to assess and assure quality of care, as well as conduct quality improvement initiatives, each state agency with responsibility for a Medicaid service or population will be provided with access to adequate and timely encounter and/or claims data as well as routine analytical reports on key indicators. State agencies will be provided with electronic access to a full spectrum of demographic, utilization and cost information about populations served by the agency. The Quality Team will develop a consistent set of minimum data elements needed by each agency. Data sharing agreements will be executed as appropriate.

The Quality Team will also develop a consistent set of quality measures to be generated routinely by the Rhode Island MMIS or other data sources and disseminated to departments and programs as appropriate. Such reports will be specific by population categories, as appropriate, and may include, but not be limited to:

- ❖ level of care determination and service authorization;
- ❖ basis of Medicaid eligibility
- ❖ access measures;
- ❖ utilization by type of service;
- ❖ clinical, quality measures; quality of life/environment; health outcome measures;
- ❖ measures of levels of functioning;
- ❖ provider profiling;
- ❖ administrative program measures;
- ❖ financial measures; and
- ❖ program performance indicators.

The Waiver Quality Director and Team will be provided with support from the waiver systems, data and information team, as well as the HIPAA compliance officer to ensure compliance with all applicable privacy and confidentiality laws and regulations.

3. Providers and health plans will be responsible and accountable for quality assurance, quality management, and quality improvement activities within their own settings, including discovery, remediation, improvement, and reporting:

The state will continue to implement measures to transition quality assurance and quality improvement activities from direct state agency-conducted activities to Health Plan- and

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provider/vendor-conducted activities. The state has already implemented this approach in its contracts with RItE Care Health Plans, and will further transition this responsibility in its contracts with Health Plans for Rhody Health Partners. The state will strengthen this transition of quality assurance, monitoring, and improvement activities through performance indicators that are contractual requirements with Medicaid direct service providers. The Quality Team will design a consistent framework and requirements for the development, submission, implementation, and reporting of provider/agency-specific quality assurance and improvement plans. This framework and its requirements will be developed with input from providers, health plans, consumers and other community stakeholders.

The Waiver Quality Director and Quality Team will partner and work closely with another interagency team established to implement critical purchasing standards across all Medicaid services providers. This “contracts and agreements team” will ensure that Medicaid contracts and provider agreements with service providers/agencies and health plans will include specific requirements for Quality Assurance and Improvement Plan submission, implementation, and reporting, as appropriate. The Quality Team will continue to work with the contracts and agreements team to ensure that compliance with the agency quality plan is integrated into contract compliance monitoring.

As a smart purchaser, the state’s role and responsibility in quality assurance and improvement becomes one of provider oversight, monitoring and technical assistance that focuses on ensuring that providers have developed and implemented their internal quality assurance and improvement plans.

4. Quality of care information will be transparent

The Assessment and Coordination Organization, described elsewhere, will be a critical link to consumers who are seeking long-term care services and/or are seeking choice counseling on care management options, by providing guidance and information about services and providers that meet the needs of the client as determined by the level of care assessment. As the quality system for the Rhode Island Medicaid program under the waiver matures with standardized reporting on key indicators, the Quality Team will develop reports about the quality of care delivered by the health plans and individual providers for use by the Assessment and Coordination Organization. The ACO will disseminate these reports to applicants and enrollees in a user-friendly, understandable format, so that consumers may make an informed choice of provider and health plan based on quality performance in areas that match their individual and family health concerns.

5. Pay for performance based on quality metrics

One of the guiding principles of the waiver is that Medicaid purchasing and payment methods will reward quality assurance, quality improvement, and cost-effectiveness. This will be accomplished by tying reimbursements to physicians, dentists, hospitals, and other providers to quality performance measures, such as patient satisfaction, access to care, and clinical and outcome measures that are tracked and improved through a provider’s quality improvement plan.

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The Waiver Quality Director and Quality Team will work closely in partnership with the team(s) in each agency responsible for provider agreements and contracts to ensure that quality performance measures are defined, measured, and rewarded through performance-based contracting.

B. STATE QUALITY ASSURANCE / QUALITY IMPROVEMENT SYSTEM COMPONENTS

The State will work with providers to ensure that quality assurance and quality improvement plans that they implement become part of a system that shall include, but is not limited to, the following:

1. Methods of ensuring the health and safety of each participant including:
 - ❖ Involvement of participants and families in care planning, identification of service needs and individual outcome measures;
 - ❖ Development and approval of various individual service and health care plans;
 - ❖ Processes for ensuring that suspected abuse, neglect, exploitation and other serious incidents are reported and investigated, as necessary; and
 - ❖ Descriptions of targeted health care outcomes for participants.
2. A process for receiving feedback from service participants and family members including:
 - ❖ Timely access to services;
 - ❖ Measurement of quality of life and capacity of alternative placements to meet identified service needs that occur as a result of rebalancing the system and care management including an analytic process with tracer components to follow targeted populations over the time period of the waiver;
 - ❖ Consumer satisfaction surveys;
 - ❖ Family satisfaction surveys;
 - ❖ Active consumer and family participation in service/treatment/care planning; and
 - ❖ A process for receiving and responding to complaints.
3. A process for monitoring provider/vendor/health plan performance and initiating appropriate actions including:
 - ❖ National accreditation of facilities and health plans;
 - ❖ On site agency reviews;
 - ❖ Licensing surveys;
 - ❖ Qualification standards and certification of clinical staff and case managers;
 - ❖ Provider network development of alternative services;
 - ❖ Focused clinical studies and medical care evaluations;
 - ❖ Submission of various data reports on population specific participants;
 - ❖ Compliance with the mandatory External Quality Review requirements (outlined in CFR Subpart E, Section 438.320) for the independent analysis and evaluation of aggregated information on the quality, timeliness, and

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- accessibility of health care services provided to Medicaid beneficiaries who are mandated for enrollment in a managed care delivery system; and
- ❖ National Child Welfare Outcomes and Standards and consistent with the Child and Family Service Review performance indicators.

4. A process for developing strategies for quality improvement including:

- ❖ Identification of *Best Practices* implemented by various state agencies and providers in Rebalancing the System, Care Management and Smart Purchasing for various population specific participants;
- ❖ A process for identifying service needs and health care trends within various population specific participants based on timely and accurate encounter data;
- ❖ A process for collecting and analyzing encounter data and using this information for quality improvement; and
- ❖ Methods for dissemination of information through departmental websites, various written reports/information and the MMIS CHOICES Module (see Appendix 1) which is currently in development.

C. REQUIREMENTS FOR SERVICE PROVIDERS/VENDORS AND HEALTH PLANS

The state will continue to implement measures to transition quality assurance and quality improvement activities to providers/vendors and Health Plans. The State and its agent(s) will be responsible for conducting oversight and monitoring functions to ensure that provider networks, institutional providers, vendors, contractors, subcontractors, and health plans comply with waiver standards. This process will include the following:

- Medicaid service provider/vendor and health plan contracts may require Medicaid providers and plans to develop and submit an annual Quality Assurance and Improvement Plan to the appropriate Department, incorporating the elements of discovery, remediation and quality improvement.
- Medicaid service provider/vendor and Health Plan contracts will require Medicaid service providers/vendors and health plans to submit all claims or encounters to the MMIS with detailed claim or encounter data requirements needed for quality metrics and reports.
- Medicaid service provider/vendor and Health Plan contracts may require Medicaid providers and plans to submit additional specific data and narrative reports, documenting the implementation of their Quality Management Plan.
- The Quality team will develop a set of provider-specific quality-related reports which may be disseminated to providers, along with benchmark data related to quality, access, and outcome of service delivery. This feedback of data to providers is critical to support successful implementation of quality assurance and improvement activities at the provider/agency level.

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- Service providers/vendors shall comply with appropriate regulations, standards and monitoring review/licensing survey and certification procedures established by the appropriate state Department or state/national accrediting agency.

D. SUBMISSION OF DRAFT QUALITY MONITORING AND MANAGEMENT PLAN

The State and its agent(s) will be responsible for conducting oversight and monitoring functions to ensure that provider networks, institutional providers, vendors, contractors, subcontractors, and health plans comply with waiver standards. This process will include the following:

1. The state will submit to CMS for approval a more detailed draft Quality Monitoring and Management Plan design within 120 days from the award of the demonstration waiver.
2. CMS will provide comments on the draft design, and the state shall submit a final Quality Plan within 60 days of receipt of CMS comments.

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Chapter Seven: Research & Evaluation Goals and Objectives

As an 1115 Research and Demonstration waiver, the Global Compact will incorporate a structured, ongoing and final evaluation that will be focused on answering four basic questions:

- b. To what degree did the demonstration achieve its purposes, including goals, objectives and measurable, quantified performance targets?
- c. Did the demonstration result in changes in health status and health outcomes for enrollees? Did the demonstration result in other outcomes for enrollees, providers and for the state?
- d. Did the demonstration result in greater value for the state's expenditures?
- e. What lessons were learned as a result of the demonstration? These lessons will result from the ongoing or "formative" evaluation, which will measure the program's progress in achieving measurable objectives, and which will provide RI with a valuable early warning system -- information that can be used for decision-making regarding midcourse corrections. Lessons learned will also be derived from the final, in depth waiver evaluation report at the end of the demonstration period, which will be of value to RI, as well as to other states who may consider implementing components of RI's demonstration.

The evaluation will be focused on measuring the degree to which the goals and objectives of the demonstration, detailed in Chapter Two, have been achieved. RI's evaluation will focus on measuring progress toward and achievement of the components of systems change that are the foundation of success for the demonstration.

A. DEVELOPMENT OF THE EVALUATION PLAN

In accordance with the Global Compact's focus on increased interagency collaboration, an interagency Evaluation workgroup will be formed to help an independent evaluator craft the short-term and long-term evaluation strategies. This workgroup, in partnership with advisory bodies and other stakeholders, will determine how the achievement of the Demonstration goals and objectives will be measured.

The evaluation of the demonstration will be conducted using a combination of program management functions for short-term monitoring, and reports and reports/studies to be conducted by independent evaluators to track long-term trends as compared to national and regional benchmarks. For example, the oversight and monitoring process and the quality assurance and improvement process led by the interagency Quality Team described in Chapter Six will generate short-term quantitative data on the progress of the demonstration. Specific indicators to be measured will be developed in coordination with the development of quality measures for the demonstration's Quality Plan, so that measures to monitor the ongoing quality of care at the plan

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and provider level will be consistent with the measures used to evaluate the program at a broader level. To the extent possible, existing efforts for data collection and analyses will be used.

The Evaluation workgroup will focus its evaluation efforts on the long-term impact of the demonstration. Quality measures will be chosen based on several factors, including appropriateness of the measure for the Global Compact's goals and objectives, the ability to obtain the measure accurately, the ability to compare or benchmark the measure against other populations, and the ability to trend the change in the measure over the life of the Demonstration. At a minimum, the Evaluation workgroup's priority evaluation areas will determine the impact of the following Global Compact objectives. The questions listed describe the types of questions that an evaluation plan may seek to answer, and address both process and outcome changes that the state intends to occur as a result of this demonstration.

- Rebalancing the Long Term Care System and De-Institutionalization across the Spectrum
 - For example, is there an increase in beneficiary/family level of awareness about and/or use of home and community based alternatives to institutional care? Is there a corresponding increase in long-term care customers' functioning and satisfaction, including, improvements in quality of life indicators, independence, and functional status?
- Care Management
 - For example, is there an increase in utilization and expenditures of primary care and preventive services (e.g. physician visits, recommended screening, vaccines) (including children, families, adults with disabilities and elderly)?
- Fair Share: "Smart" Payments and Purchasing
 - For example, have payment methodologies that provide financial incentives to appropriately rebalance the acute care system from institutional to community-based, (from hospital inpatient and emergency room to community-based primary care) been implemented and effective?
- Changes to the Medicaid financing structure
 - For example, is there an increase in utilization and expenditures of home and community based services as an alternative to institutional/residential settings, (including children, adults with disabilities and elderly)?

Rhode Island intends to work closely with CMS in developing the Evaluation Plan and will rely primarily on the CMS tool, *Evaluating Demonstrations: A Technical Assistance Guide For States*.

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B. EVALUATION PLAN

A specific Evaluation Plan, including specific evaluation measures will be submitted along with the Quality Plan, within 120 days of the approval of the waiver. Such plan will also include specific reports and timeframes, to be coordinated with reporting requirements under the Special Terms and Conditions of the waiver.

Specifically, the Final Evaluation Plan will include:

- Information about the entity or entities conducting various aspects of the evaluation;
- Timelines for implementation of the evaluation and for deliverables such as reports;
- Specific metrics and methodologies that will be used and the rationales for the selected approach, including information on:
 - the source of measures, such as whether they are national consensus measures endorsed by the National Quality Forum or publicly reported;
 - the targets that data will be collected on, such as enrollees, health plans, providers;
 - the data to be collected by the evaluation in terms of statistical reliability;
 - the validity of the measures to be used for each objective;
 - the methods by which the data will be collected, including data sources and sampling techniques;
 - the timing and frequency of collection of data on each measure; and
 - the population groups of enrollees for which data will be analyzed;
- Plan for analysis of the findings, including information on:
 - the methods by which the data collected will be analyzed, including the statistical methodologies to be used;
 - how the information will be analyzed in regard to programmatic goals, such as LTC rebalancing, quality improvement, cost-effectiveness, program efficiency, and value-based purchasing / pay-for-performance reimbursement;
 - the plan to address outcomes, limitations / challenges / opportunities, successes /best practices, interpretations, revisions to strategy or goals, and recommendations, and

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- implications of the findings at both the state and national levels.
- Data sources to be used may include, for example:
 - Eligibility system data
 - LTC assessment instrument data
 - Claims and encounter data from the MMIS
 - RI's hospital discharge data set
 - RI's MDS for nursing homes data set
 - RI's MDS for home care data set
 - Special surveys, including patient satisfaction surveys
 - Other data sets as appropriate

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Chapter Eight: Program Administration

The Consumer Choice Global Compact Waiver is a collaborative effort involving all five of the agencies under the umbrella of the Executive Office of Health and Human Services (EOHHS) as well as other units of State government, certain segments of the private sector and stakeholders. As noted earlier, the agencies under the EOHHS are the departments of: Children, Youth and Families (DCYF), Elderly Affairs (DEA), Health (DOH), Human Services (DHS), and Mental Health, Retardation and Hospitals (MHRH).

The EOHHS is currently designated in State law as the Medicaid Single State Agency in Rhode Island. The DHS now serves in this capacity under the State Plan and will continue to do so, in the short-term, while the State continues to restructure health and human services in preparation for implementation of the Global Compact waiver. Under this arrangement, the EOHHS supervises the administration of a specific set of functions the DHS is authorized to perform by State law and/or in its capacity as the interim Single State Agency. The specific administrative functions of the DHS in this respect include but are not limited to:

- ❖ Eligibility Determinations;
- ❖ Utilization Management – The DHS may require prior authorization for certain Medicaid services and is required to monitor access to and appropriate utilization of such services;
- ❖ Claims Processing – Through its contract with the State's fiscal agent for the Medicaid Management Information Services (MMIS), the DHS will provide a system for the receipt, processing and adjudication of all beneficiary claims and encounters for services;
- ❖ Member Services – The DHS will ensure the provision of traditional member services functions, including handling telephone inquiries, supporting the enrollment function, and the provision of certain member informational materials. Additionally, DHS will ensure the enrollees who are eligible will be enrolled in the Connect Care, Rite Care, Rhody Health Partners, PACE or Rite Smile;.
- ❖ Promulgation of rules and regulations pertaining to the Medicaid program;
- ❖ Providing of notice of changes in service access or delivery; and
- ❖ Ensuring fair hearing, appeal, and due process rights.

Under the Global Compact, DHS will continue to perform these functions and others required by 42 CFR Part 431 State Organization and General Administration. The EOHHS and the DHS will provide CMS with a clarification of each agency's responsibilities for other Medicaid functions during implementation of the demonstration as well as a time-line for transitioning the Single State Agency from DHS to EOHHS upon approval of the waiver.

In general, during implementation of the Global Compact, the administration of the Medicaid program will change to complement the goals of the demonstration through the increased collaboration of all five of the health and human services departments by the EOHHS. For example, under current State law, the five health and human services agencies within EOHHS have statutory responsibilities for certain populations, and therefore share in the stewardship of the Rhode Island Medicaid Program. State law designates the EOHHS as the entity responsible

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for coordinating all publicly administered health and human services in Rhode Island. In this capacity, the EOHHS will work collaboratively with the DHS and the other departments to ensure that the Medicaid program operates in a manner consistent with the State's overall approach to the delivery of health and human services.

Figure 8.1 depicts the current programmatic responsibilities of Departments under the umbrella of EOHHS.

Figure 8.1 Programmatic responsibilities of health and human service agencies in Rhode Island

Department of Children, Youth & Families	Department of Elderly Affairs	Department of Health	Department of Human Services	Department of Mental Health, Retardations and Hospitals
<ul style="list-style-type: none">• Children's Behavioral Health• Residential Placement• Children's home and community based services.• EPSDT	<ul style="list-style-type: none">• The Point (Aged & Disability Resource Center)• Assisted Living• Case Management• HCBS• Home Delivered Meals• Senior Companion• Home Health Services• Part D assistance• Companion Services• Senior Centers	<ul style="list-style-type: none">• Targeted Case Management HIV• State Laboratory• Health Information Exchange• License & Regulation Facility Monitoring• Quality reporting	<ul style="list-style-type: none">• RItE Care• SCHIP• RItE Share• Rhody Health Plan• Connect Care Choice PCCM• HCBS for Aged and Disabled• Consumer Directed Services HCBS• Nursing Facility Services• Early Intervention• Pharmacy Management• Fee for Service wrap around services• EPSDT• CEDARR Family Services• Rite Smiles	<ul style="list-style-type: none">• Adult Behavioral Health Services• Substance Abuse Treatment• Slater Hospital• HCBS for MR/DD

Formal and structured collaboration with EOHHS and the five departments will be required and implemented through interagency agreements. While these agreements exist today, they will be revised to specify the Medicaid functions to be performed by each agency as well as the respective roles of each department in meeting the goals and objectives of the Global Compact.

On-going collaboration between and among the EOHHS agencies will be reflected in the following areas:

A. PROGRAM MONITORING AND OVERSIGHT

Each Department will be responsible for ensuring the Global Compact is implemented in accordance with its goals and objectives. Interdepartmental communication and collaboration is vital to ensure early indicators of potential issues are identified. One example of this inter-

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departmental work is through the High-cost Case Review Team. This team has been in place for several years. Under the Global Compact, this team will be charged with the identification of potential systemic issues and the suggested approaches to resolution.

B. FISCAL OVERSIGHT

Rhode Island is proposing that the federal government provide Rhode Island with an aggregated allotment – global budget --with an annual inflator for caseload, utilization and cost. In exchange for assuming the risk associated with operating in this fixed sum under the life of the demonstration, the State will gain the administrative flexibility and ability to reinvest any savings required to achieve lasting Medicaid reform.

On a monthly basis, each department will participate in a financial and utilization stewardship meeting to review expenditures, caseloads, service utilization and cost drivers. If a department's expenditures fall within an established corridor indicating that the agency may exceed the amount budgeted for a particular quarter, a corrective action plan must be submitted immediately to the Medicaid agency and the EOHHS.

Departments that manage their programs within their budgets will be allowed to keep a percentage of any savings resulting from Medicaid reform or other efforts to reinvest in their programs. The remaining savings will be allocated into a reserve fund or a funding pool to be used to enhance programs, rates or services within the Medicaid program or in other state administered health care programs as determined by State policymakers and/or the EOHHS and department leaders.

The collaborative approach to financing will enable the departments to identify areas where the blending of funds might be cost-effective. An example the State is already developing is described in Chapter Two. Under the Smart Purchasing Initiative, the State is proposing to blend MHRH funding for inpatient psychiatric care for the uninsured with the DHS funding for inpatient psychiatric care for Medicaid beneficiaries. The blending of funding will increase the State's purchasing power and will provide for one system of care.

Additionally, the Medicaid Reform Act of 2008 gave the RI General Assembly specific oversight responsibilities designed to ensure the Medicaid program operates within the global budget allotment. For example, in addition to the process developed to review the financing mechanism for the waiver prior to submission, a special legislative oversight committee has been established to monitor Medicaid budget, finance and policy over the course of the demonstration once implementation begins

The authorizing statute for the EOHHS also delegates specific oversight duties relating to Medicaid to the leadership of the office. These duties include the responsibility to direct the development and monitor the implementation of department budgets for the health and human services, including Medicaid. The directors and staff of the EOHHS currently meet on a weekly basis in conjunction with this process. The Budget Office, with the RI Department of

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Administration will also play a role in ensuring that Medicaid expenditures for the EOHHS agencies remain within the parameters established by the Global Compact waiver.

C. ACCESS AND CAPACITY

The EOHHS and the departments under the health and human services umbrella will work in collaboration to ensure that an appropriate number of providers is available to serve beneficiaries across all of the programs administered under the demonstration. Under the interagency agreements with the DHS, each department will be delegated the responsibility and be held accountable for overseeing the performance of the providers delivering care and services to the Medicaid coverage groups/populations under their jurisdiction.

For example, MHRH is, and will continue to be, charged with recruiting and monitoring providers of substance abuse treatment; providers of services for beneficiaries with developmental disabilities; and providers of community-based mental health services. Similarly, the Department of Health is and will continue to be the State's survey agency and will maintain responsibility for the licensure and regulation of nursing facilities as well as for home health agencies and adult day service providers.

In the proposed Global Compact waiver, the State will retain the current process for approving and enrolling Medicaid participating providers. This means that, at a minimum, the State will continue to ensure that participating providers are licensed and/or certified when required and act in compliance with applicable Rhode Island scope of practice laws and regulations and/or federal guidelines. Accordingly, providers excluded from participation in federal health care programs under either section 1128, or section 1128 (a), of the Social Security Act or under any provision of Rhode Island General laws will be prohibited from participating in the Global compact demonstration.

D. THE ASSESSMENT AND COORDINATION ORGANIZATION

As mentioned in Chapter Two, the establishment of an interagency Assessment and Coordination Organization (ACO), under the umbrella of the EOHHS is critical to achieving the State's goal to rebalance the long-term care system. The ACO will only be successful if each Department shares information and knowledge about available services. The interdepartmental communication will ensure that Medicaid eligible individuals who needs may span across several departments can access services in the most appropriate and efficient manner.

As indicated earlier, the chief functions to be performed by the ACO include providing beneficiaries with the information needed to make reasoned choices, enabling assessment and re-assessments to ensure that the right services are provided at the right time in the most appropriate setting, and enhancing the monitoring and oversight of various services and the program. Procedures for performing these functions will be streamlined and standardized across ACO units to ensure beneficiaries are treated equitably and accountably, irrespective of the actual door they may enter when seeking long-term care services. The procedures and functions of the ACO

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provide a bridge between the acute and long-term care delivery systems and are complementary to the demonstration's care management programs.

E. EVALUATION AND QUALITY TEAM

As described in Chapter Five, EOHHS and the five departments will develop an interagency approach to the research and evaluation and quality monitoring and management of the Medicaid Program as it is implemented under the Global Compact. The interagency approach will be implemented through a Quality Team and Evaluation workgroup comprised of representatives from each Department.

EOHHS and the five departments are committed to ensuring that through the implementation of the Global Compact, the disruption in beneficiary access to services will be minimal. As new reform strategies are introduced, e.g., Healthy Choice Accounts, or as operations are being transformed, e.g., implementation of the Assessment and Coordination Organization, EOHHS and the five departments will work together to ensure that prospective and current beneficiaries, providers, advocacy organizations, the general public, and other interested parties are fully aware of the changes and their potential impact prior to implementation.

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Chapter Nine: Waivers Requested

A. PROGRAM RE-DESIGN AND INNOVATION

As noted in the preceding Chapter on the financing of the Global Compact, in exchange for the fixed federal financial contribution, the State seeks additional flexibility in the design of the Rhode Island Medicaid Program. Under the Global Compact, the state and federal governments' costs are fixed; therefore the reforms will be made in the area of eligibility and benefits. In order to implement any reforms in these programmatic areas, the State requires the ability to make changes quickly without the prior approval of the federal government.

B. FLEXIBILITY IN ELIGIBLE POPULATIONS

As stated in Chapter Four, it is the State's current intention to maintain all coverage groups now eligible under the State Plan. If, during the life of the Demonstration, the Program expenditures begin to exceed the budgeted amounts, the State reserves the right to amend who is eligible to receive services.

The State has committed to maintaining the mandatory Medicaid populations. The State does reserve its authority to impose new or revise existing cost-sharing requirements to mandatory populations.

If expenditures exceed budgeted amounts, the State seeks the ability to revise eligibility for optional populations. Any efforts in this area will be conducted in an open public process and will require the approval of the State General Assembly. Decisions to revise optional eligibility groups will not require the prior approval of the federal government, as long as the state meets its financial maintenance of effort commitment.

While the Global Compact has no immediate intention to remove any eligibility groups; the proposal does seek to add three new populations:

- Parents pursuing behavioral health treatment while their children are temporarily in state custody;
- Children who would otherwise be voluntarily placed in state custody; and
- Elders at risk for long-term care and in need of home and community-based services

Please refer to Chapter Four for greater detail on these populations. The State seeks coverage of services provided to these populations because of the long-term cost savings that will realize.

C. FLEXIBILITY IN SERVICES

As noted in Chapter Five, the State is entering into the Global Compact with no express intent to remove current Medicaid benefits. The flexibility sought under the Waiver and explained in greater detail in Chapter Five focuses on the State's ability to change the amount, duration, and

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scope of benefits. That is, to have the ability to target needed benefits to identified Medicaid eligible individuals or to grant tailored benefit plans to higher income groups that includes a high deductible (i.e.) Health Opportunity Accounts.

If however, the State finds that expenditures are exceeding the Medicaid budgeted amount, the state reserves the right to revise the benefits available under the Program. Again, the State is committed to maintaining the mandatory benefits.

If the State decides to remove certain benefits, the State will undertake a public process. Any decisions to revise the benefit package will not be subject to prior approval from the Federal Government, as long as the state meets its financial maintenance of effort commitment.

Through the flexibility allowed under the Global Compact, the State will be better able to make decisions based on the program goals and objectives, quality assurance and improvement; and patient satisfaction. If the State's management of the Program results in savings, the State is committed to reinvesting the funds into the Medicaid program or other state administered health-related programs.

D. IMPACT OF GLOBAL COMPACT ON EXISTING WAIVERS

RItE Care 1115 Waiver

Rhode Island seeks to subsume the RItE Care 1115 Waiver within the Global Compact Waiver. Any future revisions or changes to the populations, benefits, and delivery systems currently covered under the RItE Care 1115 Waiver will be pursued under the Global Compact agreement.

Home and Community Based Waivers 1915(c) Waivers

Rhode Island also seeks to subsume the nine current 1915(c) Waivers under the Global Compact. The institutional level-of-care determination will be replaced with the three-tier level-of care structure. All services currently approved under any existing 1915(c) Waiver will be available under the Global Compact Waiver as long as expenditures do not exceed the Medicaid budgeted amount. Eligibility for individuals in the special home and community-based waiver group under 42 CFR 435.217 will continue. Any future revisions or changes to the populations, benefits, and delivery systems currently covered will be pursued under the Global Compact agreement.

RItE Smiles 1915(b) Waiver

Rhode Island seeks to subsume this Waiver under this demonstration. Any future revisions or changes to the populations, benefits, and delivery systems currently covered will be pursued under the Global Compact agreement.

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Waivers Requested:

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are requested in order to enable Rhode Island to carry out the Global Consumer Choice Compact Waiver demonstration:

1. Statewideness/Uniformity 1902(a)(1)

To restrict services to certain geographical areas of the State;
To allow aspects of the program to be phased-in to new areas during the demonstration and to allow program elements to be phased-in during the demonstration; and
To enable waiting lists for optional Medicaid services and populations.

2. Reasonable Promptness 1902(a)(8)

To maintain a waiting list for optional services and optional populations; and
To require applicants for long-term care services to complete a targeted assessment.

3. Comparability 1902(a)(10)(B)

To provide nursing facility and home and community-based services based on relative need as part of the person-centered assessment and options counseling process for new applicants for such services;
To provide services under the demonstration that would not otherwise be available under the State Plan; and
To limit the amount, duration, and scope of services.
To tailor benefit plans for higher income groups with a higher deductible plan (e.g., Health Opportunity Account).

4. Income and Resource Rules 1902(a)(10)(C)(i)

To allow individuals who choose home and community based care to maintain more income and resources;
To include only the income and resources of an applicant when determining financial eligibility for individuals in certain specific coverage groups;
To enable the State to treat State contributions to Health Savings Accounts or Healthy Choice Accounts, which provide incentives/ payments to beneficiaries who reach certain prevention and wellness targets, as non-countable income and resources for purposes of eligibility or cost-sharing determinations; and
To allow the State to use the community Medicaid income and resource rules for individuals seeking Skilled Nursing Facilities services rather than long-term care rules.

5. Cost Sharing 1902(a)(14) insofar as it incorporates Section 1916

To expand cost sharing requirements above the 5% of income threshold for beneficiaries in certain populations.

6. Freedom of Choice 1902(a)(23)

To restrict freedom of choice of provider through mandatory enrollment in a managed care option and through selective contracting.

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7. Provider Agreements 1902(a)(27)

To allow for the provision of care by individuals who have not executed a Provider Agreement with the State Medicaid agency.

8. Direct Payments to Providers 1902(a)(32)

To permit payments to be made directly to beneficiaries or their representatives.

9. Retroactive Eligibility 1902(a)(34)

To waive the requirement that Medicaid be provided for only three months prior to the month in which an application for assistance is made.

10. Payment Review 1902(a)(37)(B)

To the extent that prepayment review may not be available for disbursements by individual beneficiaries to their caregivers/providers.

11. Case management regulations

To waive the requirements of proposed but not ratified codified case management regulations so Rhode Island is not subject to the requirements of the regulations if/when it goes into effect.

Expenditure Authority:

Under the authority of Section 1115(a) (2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under Section 1903) shall, for the period of this demonstration be regarded as expenditures under the State's Title XIX Plan.

1. Expenditures for Demonstration Population 1: Parents Pursuing Behavioral Health Treatment with Children Temporarily in State Custody .

2. Expenditures for Demonstration Population 2: Children Who Would Otherwise be Voluntarily Placed in State Custody.

3. Expenditures for Demonstration Population 3: Elders at Risk for Long-term Care and in need of home and community-based service.

4. Expenditures for personal care services provided by caregiver spouses and other family or relatives who provide care to disabled children, adults or the elderly.













5. Expenditures for incidental purchases paid out of cash allotments to participants who are self-directing their services prior to service delivery.

6. Expenditures related to Healthy Choice Accounts.













7. Expenditures related to Periods of Presumptive Eligibility for Individuals needing long-term care services.

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Chapter Ten: Global Compact Waiver Implementation Plan

Area	Task	Prior to Oct. 1	Year 1	Year 2	Year 3
Organization	EOHHS convenes Departments to coordinate implementation workplans				
	Assess current infrastructure to efficiently administer Medicaid				
	Develop and promulgate Rules and Regulations				
	Amend Interagency Agreements				
Communication	Continue to hold public forums and solicit feedback from stakeholders including Tribal Organizations; Consumers; Providers; and Advocacy Organizations				
	Educate provider groups and health plans about implications of proposed changes for them				
Information Systems	Establish requirements for MMIS modifications				
	Establish requirements for Eligibility System modifications				
Quality Assessment and Improvement	Develop Interdepartmental Quality Team				
	Develop and implement a consistent, coordinated quality framework and policies				
	Develop interagency coordination and communication strategy				
	Develop a consistent set of minimum data elements needed by each agency				















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Area	Task	Prior to Oct. 1	Year 1	Year 2	Year 3
	Develop consistent set of quality metric reports				
	Develop and submit to CMS a Quality Monitoring and Management Plan Design within 120 days from Waiver Approval				
Research/evaluation	Coordinate with CMS research and evaluation team to refine research questions and data collection methodologies				
	Establish internal research team				
	Analyze data and create reports				
Financial Administration	Design systems and staff to conduct tracking against global allotment by department				
Rebalancing the Long-term Care System	Increase income disregard for individuals in the community				
	Implement Presumptive Eligibility for HCBS participants				
	Apply community Medicaid rules to access short-term Skilled Nursing Facility Stays				
	Expand Medicaid eligibility for a limited benefit package to individuals in the DEA co-pay program				
	Expand Medicaid eligibility to children who are relinquished into State care for the purpose of accessing services				
	Develop One-Time Transitional Services as Core Services				













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Area	Task	Prior to Oct. 1	Year 1	Year 2	Year 3
	Develop Services to be Provided in Supportive Housing Options				
	Coordinate with Faith-based organizations to perform chore services				
	Develop new services such as medication management and flexible transportation				
	Develop and implement 3 tier LOC for NF				
	Develop and Implement 3 tier LOC for Hospital				
	Develop and Implement 3 tier LOC for ICF/MR				
	Develop and Implement Assessment and Coordination Organization				
	Develop choice counseling system				
	Develop common and coordinated screening and assessment processes				
	Implement and Expand Options for Self-Directed Care				
	Develop and expand the available community-based service for children transitioning from long-term residential facilities				
	Analyze results of Cost-finding Review and Resource Mapping Efforts				

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Area	Task	Prior to Oct. 1	Year 1	Year 2	Year 3
	Revise payment methodologies to Support Re-balancing Initiative				
	Implement prospective base adjustment to rates for homemaker; adult day services; and personal care across agencies of an amount between 5-10% of the existing standard				
	Development of rate-setting methodology for community-based services that assures coverage of base cost of service delivery as well as reasonable coverage of changes in cost caused by inflation				
	Develop targeted rate increments for medication and pain management; wound management; certified Alzheimer's treatment and support programs; and shift differentials for night and week-end services				
Acute Care: Care Management	Continue Medicaid eligibility for parents who lose custody of their children due to behavioral health needs and who seek or are in active treatment				
	Design and implement procedures for the coordination between the entities administering primary/acute care (MCOs, PCCM) and the Assessment and Coordination Organization for enrolled individuals who may need long-term care services				

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Area	Task	Prior to Oct. 1	Year 1	Year 2	Year 3
	Implement Mandatory Enrollment of Adults into a Managed Care Option				
	Implement Mandatory Enrollment of Children with Special Health Care Needs who don't have TBL into Managed Care				
Fair Share: "Smart" Premiums and Co-pays, Pricing and Purchasing	Develop and Implement Healthy Choice Accounts				
	Enhance Rite Share Program to maximize available third party liability				
	Raise Rite Care Premium Rates to 5% of Income (families above 150% FPL)				
	Impose Rite Care Premium rates at 3% of Income (families 133-150% FPL)				
	Impose Co-pays for Rite Care families: inappropriate ED and prescription drugs				
	Implement Selective Contracting for Inpatient Psychiatric Care				
	Implement Selective Contracting for Specific Outpatient Services				
	Add anti-psychotic medications to the Preferred Drug List				
	Implement Long-Term Care Partnership Program				
	Develop and Implement Reverse Mortgage Partnership Program				

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Appendix I

Aligned Projects and Initiatives That Will be Integrated Under Rhode Island's Global Compact Waiver

RI-Real Choices Systems Change Project 2006 (EOHHS, DHS/Medicaid): The purpose of this project is to re-balance the long-term care delivery system funded by Medicaid to one that promotes capacity in the home and community based service setting. The blueprint for making this change is the Rhode Island LTC Strategic Plan. This project has broad community stakeholder involvement from both the provider and consumer advocacy settings. Key systems changes that it is implementing are: screening and assessment for long-term care needs; provider capacity building; and financing.

THE POINT: Rhode Islands Aging and Disability Resource Center Project 2006 (DEA, DHS/Medicaid) The ADRC is a federally funded initiative by The Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS). The focus of the ADRC is to serve as the primary gateway to home and community-based long term care services and institutional care. The ADRC ensures that all individuals have access to information, assistance, assessment and counseling services regarding home and community based services, institutional care and any other related long term care services. DEA has been funded to develop and operate an ADRC since 2003. The RI-ADRC is currently known as THE POINT.

RI Medicaid - HIE Integration Initiative / RItResources 2008 (EOHHS, DoH, and DHS/Medicaid): This initiative draws from a Medicaid Transformation Grant funding source. It seeks to add components to the statewide Health Information Exchange currently under development that add the highest value to the Medicaid program (e.g., including data types like radiology and discharge summary reports and medication history from nursing home stays; and increasing the number of Emergency Department and nursing home users.) It also seeks to build an online information system (RItResources) that promotes hospital discharge to home and community based settings by allowing hospital discharge planners to search for real-time availability among home and community based service providers, and to view characteristics of those providers that would best meet the needs of every individual.

RI Medicaid MMIS Choices Module (DHS/Medicaid, EOHHS, DEA and MHRH): The MMIS Choices Module will build a Data Warehouse that will combine data from many different sources in one central location for efficient, one-stop reporting and analysis. All services supplied to a single client from multiple programs will be viewed through a web browser in a single report. Additionally, a Community Supports Management application will be built with major functions including providing electronic assessment tools and service coordination/case management tools for the state workforce.

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RI Emergency Department Diversion Project 2008 (DHS/ Medicaid): This grant is for \$4.2 million over a two-year period. These grant funds allow States to establish alternate non-emergency service providers so that treatment can be received in alternative settings for the same condition at lower cost. This network of providers will build on the collaboration established between the RI Community Health Center Association and the Hospital Association of Rhode Island, the efforts underway with the managed care health plans to reduce ED utilization, the established medical and behavioral health collaborative practice models, and recognized Child Psychiatry Access Project models.

Wraparound Rhode Island (DCYF): This initiative introduces wraparound system of care principles and practices throughout the RI children and family services system. The goal of the initiative is to reduce reliance on 24-hour congregate care and residential treatment centers and increase access to and utilization of community based alternatives. Through the wraparound system, the DCYF will use flexible funding to finance services for children and families that are matched more closely to their needs. The focus will be on providing these beneficiaries with an expanded array of home and community-based services and supports. The DCYF is contracting with established networks of providers to extend the continuum of care to include a broad menu of these services and supports.

The Rhode Island Chronic Care Collaborative and Connect Care Choice (DoH/Medicaid): The community health centers and private primary care provider offices that participate in the Rhode Island Chronic Care Collaborative are among those providers in Rhode Island who are building an advanced medical home for their patients. Rhode Island's Primary Care Case Management program, Connect Care Choice, combines the training that these providers have received with financial incentives to ensure that adults with disabilities who are Medicaid beneficiaries receive the greatest amount of care management from within an advanced medical home.

Chronic Disease Self-Management Program (DoH/DEA/DHS): The State of Rhode Island has received funding to train leaders at community-based organizations in the Chronic Disease Self-Management Program developed at Stanford University. These community-based organizations now lead groups of their clients, including Medicaid beneficiaries referred to them by their primary care providers, to encourage self-management techniques for a variety of chronic disease.

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Appendix 2

Public Forums, Budget Hearings, and Stakeholder Meetings Regarding the Global Compact Waiver

Many of the concepts included in the Rhode Island Medicaid Global Compact Waiver were raised during stakeholder workgroup meetings and public forums related to ongoing efforts to institute changes in the Medicaid program, such as those related to the Real Choice Systems Transformation Grant (to re-balance the long-term care system) and the Managed Care Options for Adults with Disabilities and Elderly (i.e., Rhody Health Partners and Connect Care Choice). Listed below is a table of Public Forums, Budget Hearings and Stakeholder Meetings that have been accomplished regarding the Global Compact Waiver.

GENERAL PUBLIC FORUMS

Date	Location	Group	Approximate Number of Attendees
February 13, 2008	State House Rm 313 Providence RI	Lt. Gov Long Term Care Coordinating Council	41
March 13, 2008	Department of Labor and Training, Cranston, RI	Governor's Cabinet on Chronic and Long Term Care	15
March 20, 2008	State House Rm 313 Providence RI	Lt. Gov Long Term Care Coordinating Council	33
May 8, 2008	Department of Labor and Training, Cranston, RI	Governor's Cabinet on Chronic and Long Term Care	15
June 5, 2008	Community College of Rhode Island, Warwick, RI	Children's' Roundtable	125
June 9, 2008	University of Rhode Island, Kingston, RI	General Public	35
June 11, 2008	Rhode Island College, Providence, RI	General Public	65

BUDGET HEARINGS

Date	Location	Group	Approximate Number of Attendees
April, 3, 2008	House Finance	Legislators/General Public	50 and Public Access TV
May 11, 2008	House Finance	Legislators/General Public	50 and Public Access TV

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May 13, 2008	Senate Finance	Legislators/General Public	50 and Public Access TV
May 17, 2008	House Finance	Legislators/General Public	50 and Public Access TV

STAKEHOLDER GROUPS AND PROVIDERS

Date	Name	Number of individuals (i) or leadership (L)
March 28, 2008	Real Choices Stakeholders	13
March 31, 2008	Real Choices Stakeholder Finance Workgroup	11
April 11, 2008	Real Choices Stakeholders	12
April 28, 2008	Real Choices Stakeholder Finance Workgroup	13
May 2, 2008	Real Choices Stakeholders	11
May 6, 2008	Governor's Council on Behavioral Healthcare	(i) 26
May 16, 2008	Real Choices Stakeholders	13
May 19, 2008	Phoenix House Annual Meeting	(i) 45
May 19, 2008	Real Choices Stakeholder Finance Workgroup	12
May 23, 2009	Pathways to Recovery (MH)	(i) 100
May 28, 2008	Opportunities Unlimited	(L) 2
May 28, 2008	Gateway Mental Health	(i) 1
May 30, 2008	CEO's – Mental Health Centers	(i) 8
May 30, 2008	Real Choices Stakeholders	11
May 30, 2006	Kent Center	(L) 2
June 2, 2008	DD Family Group	(L) 2
June 3, 2008	Perspectives (DD)	(L) 1
June 5, 2008	Community Provider Network of RI (CPN/RI) DD	(i) 52
June 13, 2008	Real Choices Stakeholders	12
June 16, 2008	RIARC	(L) 2
June 16, 2008	Real Choices Stakeholder Access Workgroup	10
June 17, 2008	Mental Health Association (MHA)	(L) 5
June 17, 2008	Disability Law Center	(L) 3
June 18, 2008	RI Drug and Alcohol Treatment Association	(i) 34
June 18, 2008	Developmental Disability Council (DD Council)	(i) 60
June 19, 2008	Trudeau Annual Meeting (DD)	(i) 60
June 27, 2008	Real Choices Stakeholders	10